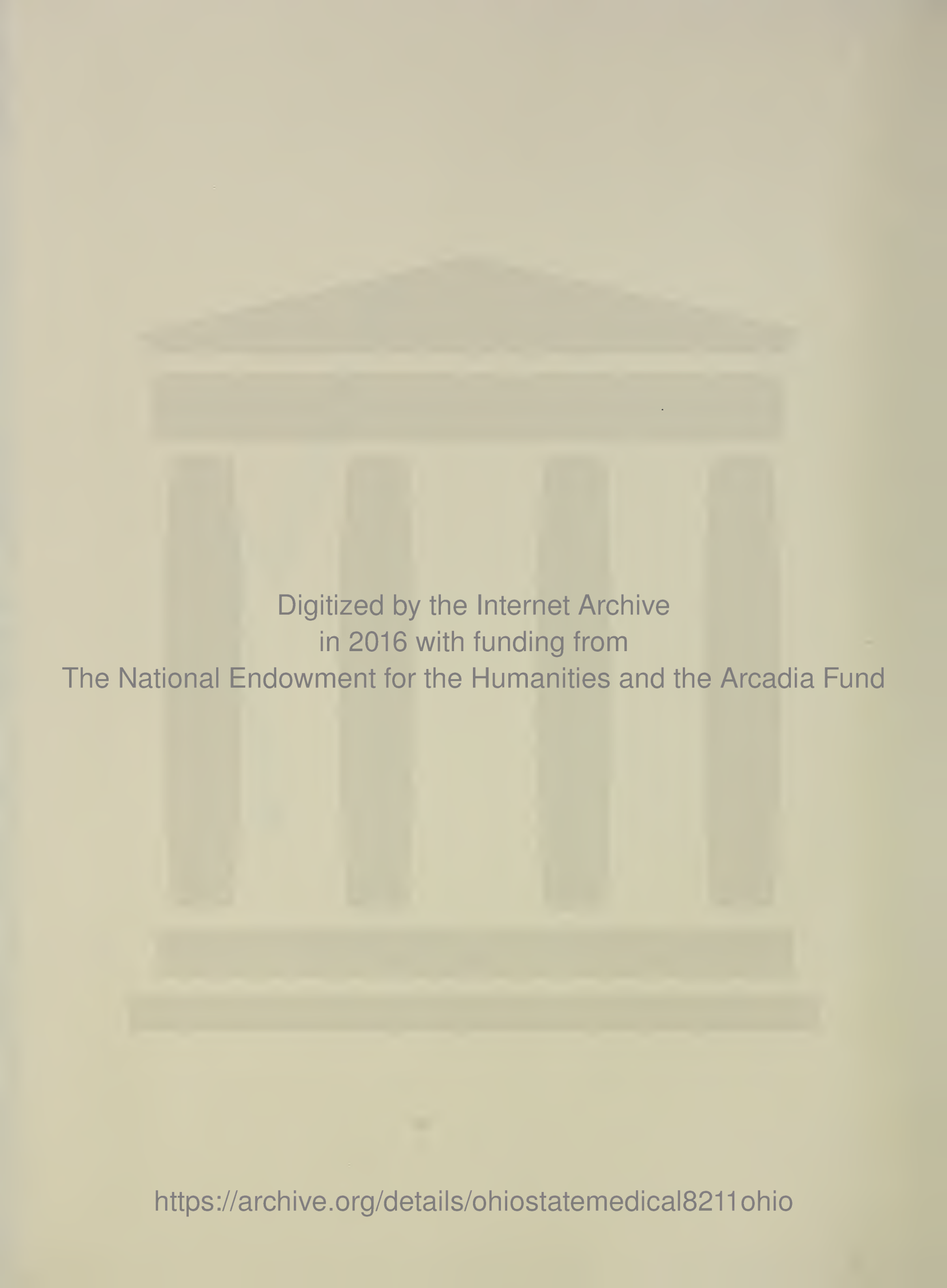
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THE Ohio STATE Medical Journal

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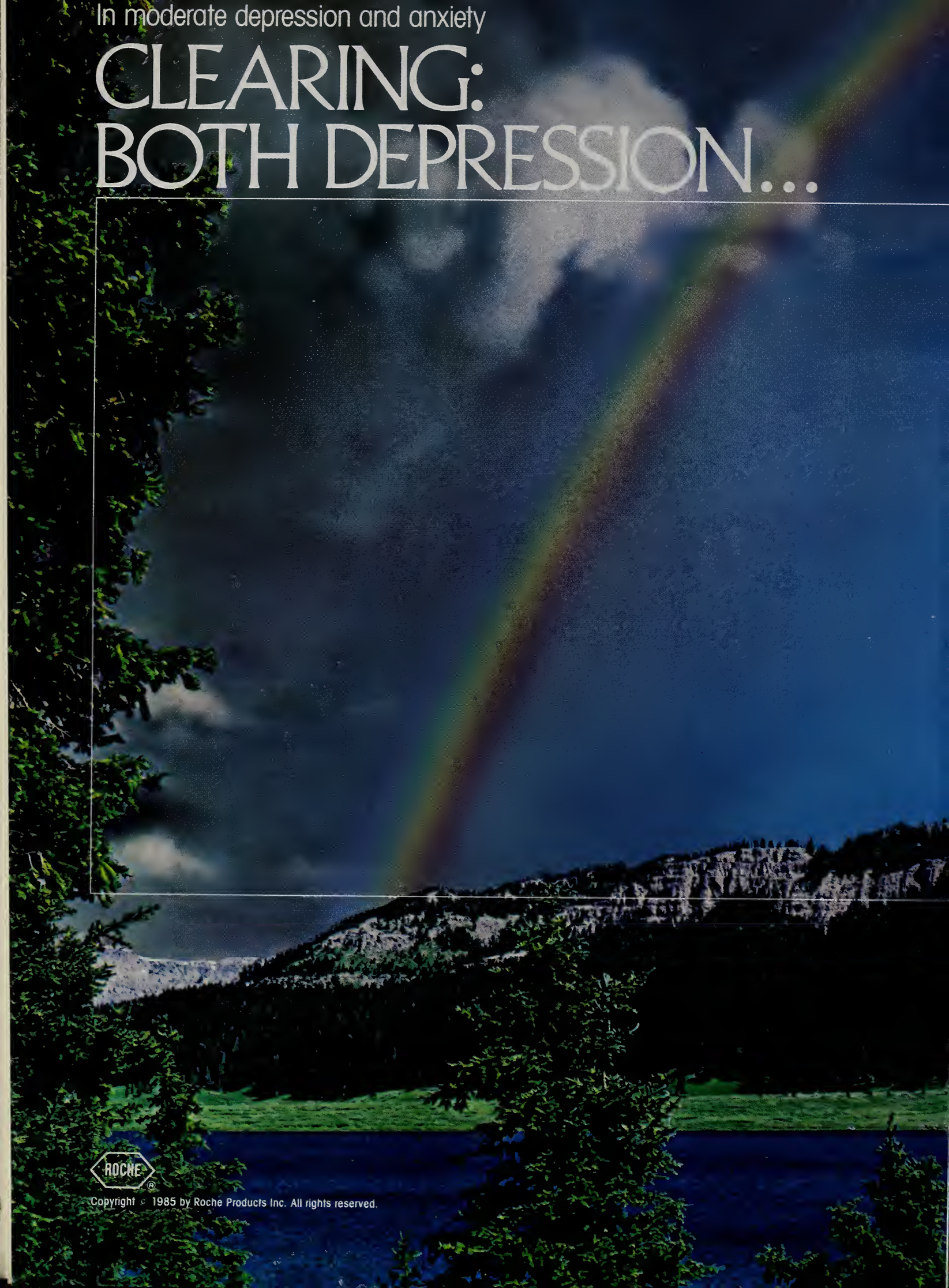
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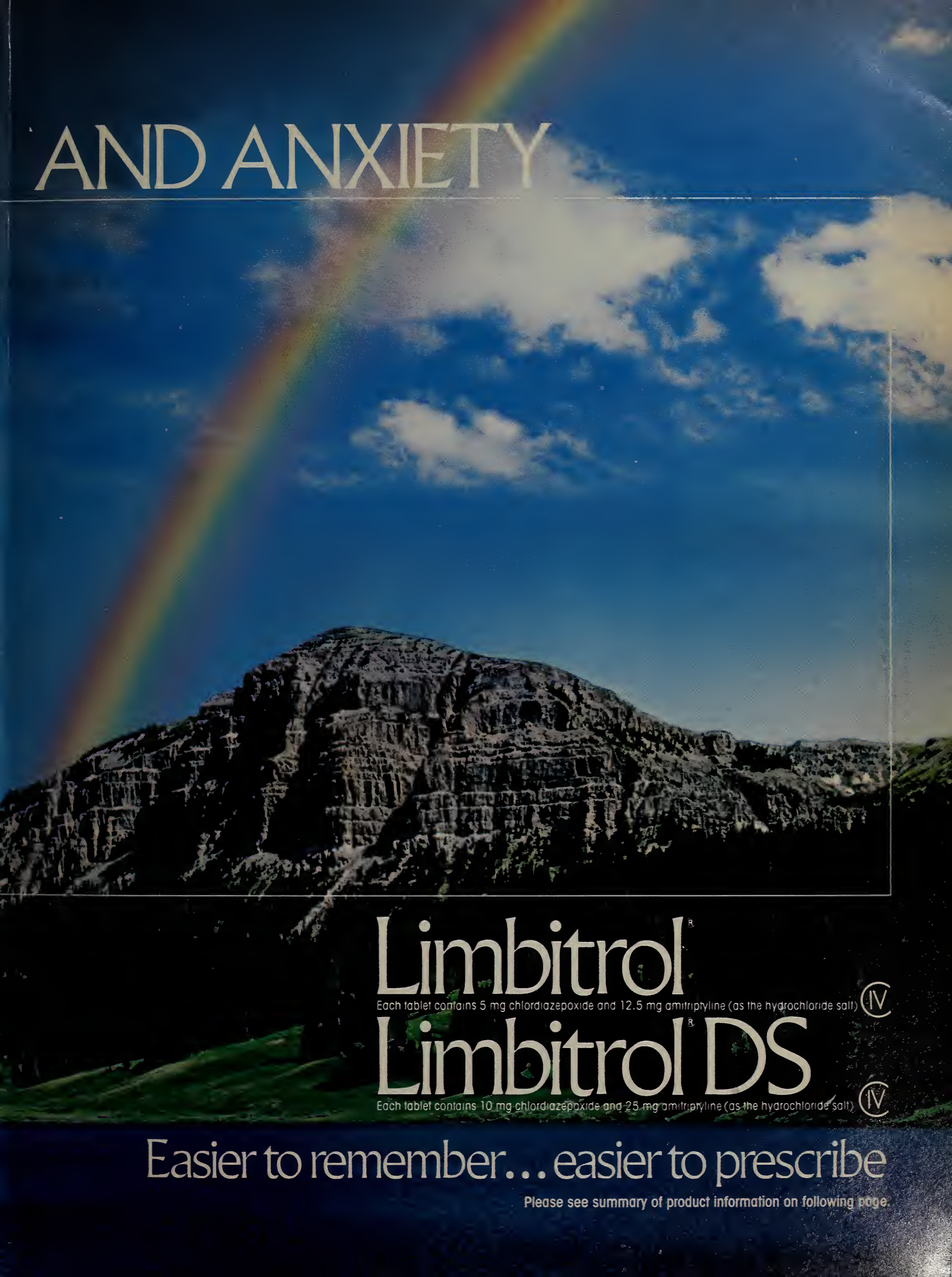
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Herman I. Abromowitz, MD

=PRESIDENTIAL PERSPECTIVES=

Physicians at the Forefront

By Herman I. Abromowitz, MD

This January issue of the Ohio State Medical Journal discusses a serious concern to all of medicine and to the patients we serve: the diversion and abuse of prescription drugs.

According to federal government reports, abuse of prescription drugs results in more injuries and deaths to Americans than all illegal drugs combined. Of the 1.5 billion prescriptions dispensed in the U.S. each year, several hundred million dosage units are diverted to illegal use. Approximately 80 to 90% of these diversions occur at the hospital, practitioner or community pharmacy level.

Medicine has been under siege from people who charge that we should "clean our own house." Critics charge that physicians and other health professionals "overlook too often" when mistakes or problems arise and that they protect themselves at the expense of the public. My years in the practice of medicine tell me this just isn't true. Virtually all physicians I know are concerned, caring individuals who put the interests of their patients first. They are even more outraged than the general public at abuses that affect the health of our patients.

It is for this reason that the OSMA asked the American Medical Association for its assistance in implementing the Prescription Abuse Data Synthesis (PADS) project in Ohio.

The AMA developed and funded this program, which is designed for use by state medical societies, in an effort to identify and resolve problems with drug diversion and abuse within a state.

I feel, as did the other professional associations who participated in this project along with many other state agencies and boards, that if there is a problem with health professionals diverting and misusing drugs, then it is incumbent on the professions to take the lead in solving the problem.

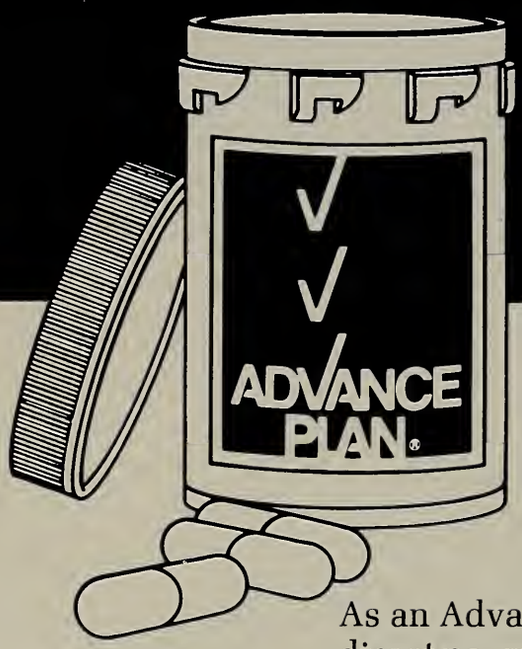
The PADS report which is contained in this issue of the Journal describes the program in full, including the recommendations of the committee to help in resolving the problem.

This report was officially presented to Governor Richard F. Celeste on December 3, 1985 at a special news conference held in the Governor's Cabinet Room at the Statehouse.

The commitment of the AMA and the OSMA to this project was demonstrated by the presence at this special conference of Harrison L. Rogers, MD, President of the AMA, and myself, President of the OSMA. David Jackson, MD, Director of the Ohio Department of Health, and OSMA staff were also present as well as representatives of many of the participating agencies and members of the news media.

All physicians should be very proud of this report because it demonstrates that physicians and other health care professionals are concerned and deeply committed to protecting and preserving the high quality of health care in Ohio and are willing to address critical problems whenever and wherever they arise. The OSMA is at the forefront of this commitment.

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Medicine's Past Predicts the Future

It's difficult to begin a new year without taking at least one retrospective glance back at the old. In a sense, that's what this issue does. Although each of the articles we've included look to the future, their roots are firmly implanted in the past.

Take our cover story, for example. The Prescription Abuse Data Synthesis Program (PADS) can actually trace its roots back to 1983, when the Council of the OSMA first endorsed the idea of implementing the AMA developed and funded program, and Ohio Council took this action in response to the increasing problem of prescription drug diversion and abuse in Ohio. Following subsequent contacts with appropriate state agencies and organizations which deal with prescription drug abuse, it was determined that the climate was right for the implementation of PADS in Ohio; and, in May of 1985, the first meeting was held. In December, the PADS group presented the results of its study to the Governor. We think you'll find the article about PADS both interesting, informative . . . and one other thing. Hopeful. Despite recent publicity that has cast aspersions on the medical profession and its regulatory agencies, we think you'll agree that PADS is a perfect example of how Ohio physicians can and do work together to take care of their problems . . . and to assure the continuation of quality patient care in this state.

Of course this issue also contains the annual "Legislative Update" — and here you'll find the real essence of 1985. The Nurse-Practice Act, the allied professionals' move for increased scope of practice — all the medical-political issues that transpired last year are synopsized for you in this piece. If you want a good look at what the 1986 legislative year has in store for medicine, this is the article you'll want to read.

And if you want a good picture of the encroaching liability problem, look up the overview written by Tom Cashman, Associate Director of OSMA's Department of Communications, on the recently required $1 million professional liability coverage, passed down by St. Paul Insurance Company late last year.

Ohio Medi-scene also returns to the past with an article that explores the return of the house call, and another on how one Ohio crisis center is handling some of the problems brought on by the deinstitutionalization of the mentally ill.

But if it's *future* you'd rather think about, be sure to turn to the hotel reservation form for this year's Annual Meeting in Dayton. It never hurts to sign up early for this exciting event.

"Councilor Commentary" visits Districts One and Eleven this month for comments from Councilors Stanley Lucas, MD, and D. Ross Irons, MD, respectively. Here again, you'll find the past mixes inevitably with what lies ahead.

And what *does* lie ahead for medicine during 1986? Only time can answer that one — but rest assured that whatever is in store, the *Ohio State Medical Journal* will be bringing it to you — as quickly and as succinctly as we can. — *Karen S. Edwards*

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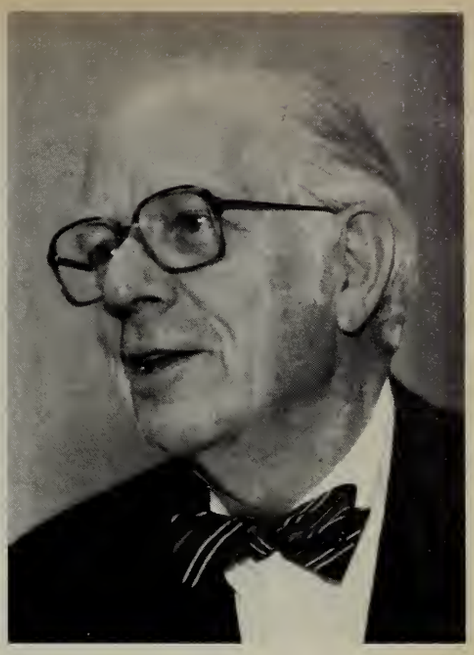
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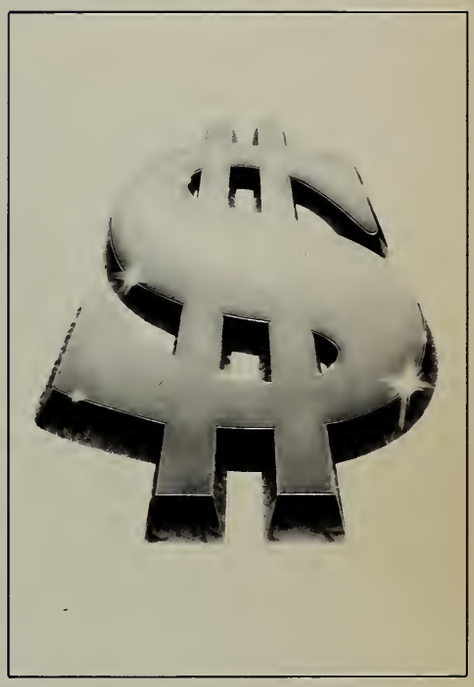
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Antitumor Antibiotics: A Prediction

By Leonard Greentree, MD

It is predicted that antitumor antibiotics will play an important role in winning the final battle against cancer. The following observations provide the rationale for making this prediction a reality.

During the past few years, a great number of living microorganisms in the soil and elsewhere have been found to have antitumor properties of varying degrees. Unfortunately, most of them have proved to be far too toxic for clinical use against human cancer. On the other side of the coin, it should be noted that the antitumor antibiotic Adriamycin (isolated from the mold *Streptomyces peucetius vr. cassius*) was one of the two most profitable cancer chemotherapy agents for the American Pharmaceutical Industry for the year 1983. Both Mitomycin (isolated from the broth of *Streptomyces caespitosus*) and Bleomycin (isolated from a strain of *Streptomyces verticillus*) were also included in the eight most profitable cancer chemotherapeutic agents for the same year in the United States.

In this line of thought, Hill and his associates present evidence that anaerobic bacteria in the colon have the potential to degrade the increased secretion of bile (resulting from excessive fat and meat in the human diet) into carcinogens and co-carcinogens causing cancer in the colon at a later date. Considering the Chinese philosophy of *yang* and *yin* of opposite effect as they relate to events in the human life, it is speculated that antitumor microbes will be found in the colon, thereby retarding the spread of cancer in humans. In this line of thought and of considerable importance, the late Charles W. Mayo (one of the two brother founders of the renowned Mayo Clinic in Rochester, Minnesota) is reputed to have said that he doubted if there are people 100 years of age without cancer somewhere in their bodies. If this viewpoint holds true, colon endoscopy and/or repeated stool cultures in such elderly individuals conceivably should uncover effective antitumor microorganisms with little or no toxicity evident during treatment of the general population with malignant tumors.

All life on earth reflects constant interaction between living things, and they assume different sizes and shapes as environmental conditions change and a mutant creation makes its appearance in later generations. Human cancer illustrates microbe interaction at its worst; where defective genes and microbe interaction play the dominant role in causing cancer; where radiation and other carcinogens in the external environment merit serious consideration; where a pampered lifestyle makes an individual more prone to the development of cancer at a later date. Antibiotics revolutionized the treatment of infectious disease roughly 40 years ago. Antitumor antibiotics should do the same for cancer hopefully in the foreseeable future! **OSMA**

Leonard B. Greentree, MD, is retired and lives in Columbus.

News Digest

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AIDS in school

At a recent meeting of the OSMA's Committee of Public and School Health, members discussed the possibility of developing guidelines which would address the issue of whether children with AIDS should be allowed to attend public school.

Although it was recognized that it would be very difficult for any medical group to outline clear, precise guidelines on the subject due to individual cases and lack of information about the disease, a subcommittee was appointed to consider the AIDS-in-school question in more detail.

Human gene experimenters receive federal guidelines

Researchers conducting human gene experiments have recently been handed a set of federal guidelines to follow — the first time specific provisions have been given investigators involved in this area of study.

Before the government will consent to specific trials for patients, it asks applicants to describe:

- the potential benefits and hazards of the proposed therapy
- the risks and benefits
- the likelihood that the added DNA will spread to other people
- precautions against spread
- the specific treatment that will be administered
- the diagnostic methods that will be used to monitor its success or failure.

The guidelines also request research teams to submit the qualifications of its investigators, the adequacy of lab and clinical facilities, patient selection techniques, informed consent procedures and confidentiality measures.

Information submitted will enable the government to "assess the likelihood that the proposed therapy will inadvertently affect reproductive cells or lead to infection of other people" — two "undesirable" consequences the government hopes to avoid.

Testing your health care IQ

If "Trivia Pursuit" always leaves you feeling like an idiot, here's your chance to show your friends and relatives how much you *really* know, given the right subject, that is.

The Medical Society of the State of New York is offering its own health care version of the trivia game, with a series of questions on such "up-your-alley" topics as basic anatomy, medical history, famous physicians, personal health, nutrition and disease prevention. Questions are also included on how to get the best medical care while containing spiraling costs.

But don't get *too* confident. While you may be able to breeze past questions like "what's the more common name for the tibia?" and "where do you find your patella?," you may well be brought up short when asked about famous physician-poets, or when anesthesia was first widely used.

For more information on the game, contact the Medical Society of the State of New York, 420 Lakeville Rd., Lake Success, NY 11042.

Edited by Deborah Athy

Ohio news-briefs . . .

Raising doctors' cost-consciousness . . . In response to the recent article, published in the *Journal of the American Medical Association,* which states as much as $32 billion worth of health care is of no demonstrated value to those who receive it, studies are now being conducted around the state which are specifically designed to raise the cost-consciousness of physicians. One of the most unique efforts in this area is being conducted at Children's Hospital in Columbus, where doctors who practice there are receiving copies of their patients' bills. The doctors do not have to pay them, but they do make the physicians aware of the cost of each of their prescribed procedures. "When you see everything itemized and added up, you say 'Holy Cow!' " says Ronald Berggren, MD, former president of the Academy of Medicine of Columbus and Franklin County.

Aging research . . . Members of the Ohio State Medical Association Auxiliary and the American Federation for Aging Research-Ohio Affiliate are launching a statewide effort to educate Ohio's citizens about the need for basic research into the aging process. They will be seeking funds to support these research projects.

HMOs are gaining approval

The nation's physicians appear to be more positive about health maintenance organizations (HMOs) than in recent years, according to a national survey conducted by Louis Harris and Associates.

The survey, "A Report Card on HMOs: 1980-1984," reported that half of the country's physicians are favorable about HMOs today — compared with 36% who were favorable in 1981.

HMOs, which provide subscribers with nearly all of their medical care for a prepaid premium, currently have more than 15 million members across the nation.

"There is dramatic evidence that the rapidly growing HMO movement has had a significant impact on physicians in recent years," said Humphrey Taylor, president of Louis Harris and Associates.

For example, only 27% of the physicians surveyed in 1981 said they would consider affiliating with an HMO; by 1984, this number had nearly doubled.

Of the fee-for-service physicians surveyed, 18% said the presence of an HMO in their area has reduced their income.

And although "by a great majority — 78% — physicians believe HMOs are effective in containing health care costs," about two-thirds believe that the "cost containment incentive causes HMOs to lower the quality of care



to an unacceptable level," Taylor said.

Many physicians believe that HMOs perform fewer lab and diagnostic tests than may be necessary, employ less qualified doctors, and do not allow for adequate doctor-patient relationships, Taylor explained.

However, "there is no evidence in the survey that HMOs employ physicians of lower caliber," Taylor said. And what's more, the survey revealed that HMO subscribers are pleased with the medical care they receive.

So although some physicians still have reservations about HMOs, the overall outlook is improving, Taylor added.

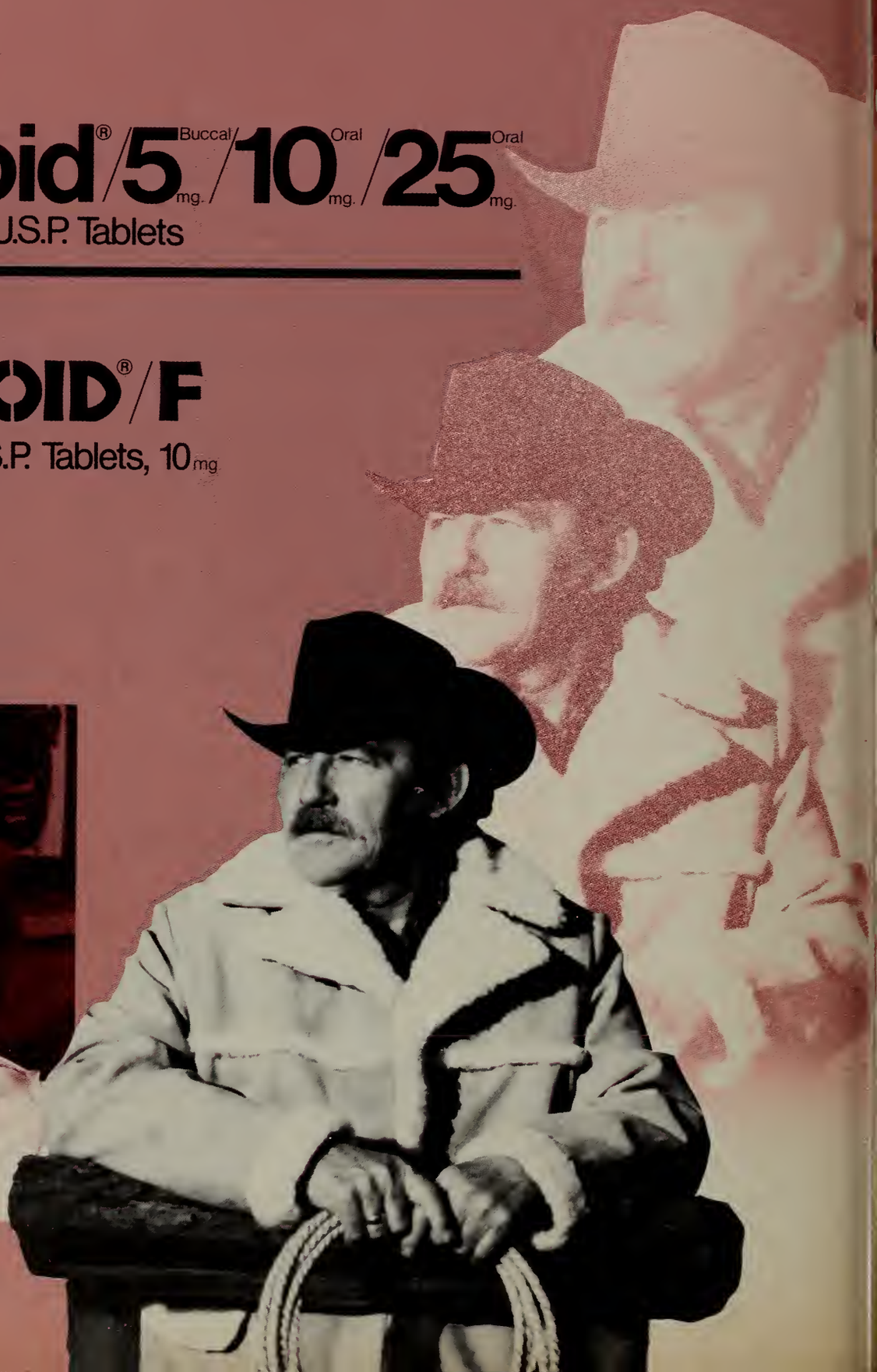
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Ohio medi-scene

Help for the deinstitutionalized . . . The return of the house call . . . Nominations due for president-elect and resolutions . . . Gearing up for retirement . . .

How one Ohio crisis center is handling deinstitutionalization

Since the early 1970s, the state of Ohio has recognized the need to integrate mentally retarded citizens into the normal life of the community. Through the de-institutionalization process, many former residents of developmental centers live and receive services in community-based residential facilities. In many of these facilities, the staff does not have the experience necessary to handle the complex type of behavior disorders that may be exhibited by a small percentage of this population. This is especially true for the mentally retarded person who is also mentally ill (MI/MR). Therefore, the MI/MR person may be given inadequate and/or inappropriate treatment and sometimes must be returned to an institution.

Some service providers (e.g., group homes, parents, guardians) for the MI/MR population expressed an interest in the establishment of a facility that might provide a treatment alternative. On February 1, 1985, a Regional Crisis Center, associated with an already established Mental Health Center, opened at Madison County Hospital in London, Ohio. This Regional Center seeks to provide better community-based care and reduce readmissions to the state developmental centers. The services provided are: a.) In-patient care using the present 10-bed mental health unit. This unit provides facilities necessary for a seven- to 14-day evaluation period not presently available at any other private facility. b.) Out-patient care that provides initial or follow-up care by a mental health team, i.e. psychiatrist, nurse, mental health technician, pharmacist and any other professionals deemed necessary.

Included in both the in-patient and out-patient component is training available to help the community care-givers develop expertise in helping their MI/MR clients. This "team" approach provides a vital "link" between the service providers and the professionals at the Crisis Center. If evaluation by the treatment team of the Crisis Center determines that the community service providers cannot meet the needs of the client, recommendations can be made for placement alternatives.



Profiles of Patients

Thirty-two clients were treated as in-patients in the Center's first six months of operation. The psychiatric profile varied:

Acute psychotic episode with obsession, agitation and depression — 3
Psychotic depression — 1
Panic disorder — 1
Aggressive behavior with organic personality — 2
Compulsive personality — 1
Aggressive behavior disorder — 13
Medication adjustment — 2
Legal or placement complications — 8
Adjustment reaction — 1

Patient Origin

The patients came from 14 Ohio counties: 26 came from counties within a 50-mile radius of the Center; six came from beyond a 50-mile radius; and 25 percent of the patients were referred by one nearby county, Champaign.

Treatment

The background of MI/MR patients varies greatly. Treatment methods are determined by

How one Ohio center is handling deinstitutionalization . . .

continued

1.) level of retardation,
2.) psychiatric diagnosis,
3.) behavior programming and medication histories and
4.) residential status, i.e. group home, parental home or living alone. Final treatment recommendations are listed below:

1.) **No medication changes:** Nine patients received no medication adjustment after evaluation. Recommendations were made, however, for changes in programming or living arrangements. Four of these patients were recommended back to institutional facilities.

2.) **Psychotropic medication changes:** "A" patients were discharged with some change of psychotropic regime. Many patients referred to the unit were being treated with a major tranquilizer (antipsychotic) at the time of admission. However, there are several other classes of standard psychotropic medications, e.g., antidepressants, lithium and stimulants, which are useful for symptoms not helped by antipsychotics. These medications are used alone or with the antipsychotics.

a.) **antipsychotic medication (major tranquilizers):** In the 1970s, it was common to treat aggressive behavior in the mentally retarded with high doses of these drugs, e.g., 2000 mg. of Thorazine per day. In 1985, such high doses are rarely used. Although the indication of these medications is confusing, it is the center's experience that a fairly high percentage of aggressive mentally retarded individuals may show improvement when given antipsychotics and, in fact, they may demonstrate psychotic-like disorientation if the antipsychotics are discontinued. However, the center found the doses should be kept low. "B" individuals were discharged from our unit on an antipsychotic medication. An individual may come to the clinic on 300 mg of Mellaril per day and be sent home with the equivalent of 50 mg. per day, along with other medications to help control impulsive aggression.

b.) **Antidepressant medication:** Three individuals were placed on antidepressants for obvious symptoms of depression with obsessive psychotic thoughts. Antidepressants were also used to treat psychotic obsessive behavior.

c.) **antiadrenergic medications:** It is the experience of the center that adrenergic upset is the most consistent demonstrable factor related to the various behaviors of the mentally retarded. Aggressive individuals frequently demonstrate continuous or intermittent tachycardia, hypertension, tremor, peripheral vasoconstriction and dilated pupils. Use of the "antiadrenergic medications" frequently lowers the "tone" of the body upset allowing careworkers to deal better with the behavior problems without using prolonged and heroic efforts of physical restraint.

d.) **antianxiety medications (minor tranquilizers):** These were used in only "E" patients mostly to enhance sleep at night. Most retarded individuals in the community function in workshops or schools and do not tolerate high doses of these sedating medications.

e.) **psychostimulants**

f.) **anticonvulsants**

Length of stay

Total admissions: 32

24 patients stayed less than 15 days

8 patients stayed more than 15 days

— 3 of these had legal or placement problems

— 5 had complications of diagnosis or medication regimes.

Conclusion

In reviewing the first six months of experience, it was shown that a short-term hospitalization of one to two weeks can be quite useful for diagnostic evaluation, medication adjustment and initiation of changes in behavioral programming. Of the 32 patients admitted, 11 had a very significant improvement in their life functioning as the result of the hospitalization; e.g., they were able to return to a workshop, were able to stay home with their parents or in the group home setting, etc.

Plans have been initiated for building a semi-independent facility for the care of individuals who require a higher level of care for behavioral and daily living

needs.

It is hoped that this Regional Crisis Center will serve as a "model" for the development of other regional centers in Ohio. As "pioneers" in the field, the staff of Madison County Hospital, Inc. can share its expertise with others and thereby expand quality care for the MI/MR person in Ohio.
— *Ralph Ankenman, MD, and Christine Murphy, RN*

MEDICINE: WHERE DO WE GO FROM HERE?
MAY 2-7, 1986 STOUFFER DAYTON HOTEL/CONVENTION CENTER

Nominations for President-Elect and 1986 OSMA resolutions

Deadline for nominations for the office of President-Elect and submission of 1986 resolutions to the House of Delegates is — **March 3, 1986.**

The return of the house call

An old stereotype has been resurrected. Dressed in white and toting their proverbial black bags, doctors are once again making house calls. Some doctors, that is.



A Cleveland-based company was not content to keep the chapter closed on this medical tradition from the past. With a staff of eight doctors on the medical beat, 10 consulting doctors, and approximately 150 supporters, including nurses, technicians and therapists, American Physicians and Nurses Home Care Services (APN) has been responding to house calls since March.

"It (home health care) is a return to the past of sorts," says Carol Schaffer, a nurse-attorney and APN's administrator. But more importantly, it is a response to medicine's present DRG atmosphere.

According to Schaffer, DRGs have induced hospitals to discharge patients earlier than they used to, resulting in a greater number of "sick patients being thrust into the community."

Consequently, many patients may need a great deal of initial care once they have returned home; but, in many cases, families of these patients are unprepared and ill-equipped to provide this care.

This situation is especially true in the case of the elderly — a segment of the population that continues to grow and where complications in illnesses are most likely to occur.

Another situation that necessitates home health care occurs when patients are not mobile enough to leave their homes. "Some homebound patients have not had a physical in years," Schaffer says.

Ohio medi-scene . . . continued

The return of the house call . . .

continued

Home health care has never really become a lost art, she points out. "Community nursing has been going on for a long time" — but, she adds, physicians also needed to get involved, and APN is the first company to take that step and provide physician care as well as nursing care to homebound patients.

Certainly, as APN president, Igor Lantsberg, MD, pointed out in a recent Cleveland Plain Dealer article, the increasingly complex medical needs of patients at home create a demand for doctors trained in the latest medical procedures to treat them. But there is no doubt that competition also accounts for some of this renewed interest in house calls.

"Overtime, there will be a definite trend in which doctors will be looking for new patients to fill their caseloads," Schaffer says — a switch from the past, when "the doctor was a scarce beast of sorts." Then, when a patient needed to see a physician, "it was necessary to come to the office and wait awhile."

More and more, however, it has become important for doctors to travel new avenues in medical care. "There must be an openness to alternative methods of delivery," she adds.

The image of the doctor who makes house calls is also changing. "In the past, home health care was not particularly seen as the epitome of medicine — it was more of a nursing or support function — not a diagnostic or intensive care situation. It didn't have the glamour of other fields of medicine."

But times are changing. "Community medicine is starting to gain an appeal it has not had before," Schaffer concludes. — *Deborah Athy*



How to gear up for retirement

In an age when liability premiums are reaching sky-high limits, and increasing competition and government regulation are taking the "fun" out of the traditional practice of medicine, retirement offers an attractive alternative to the physician who feels he or she is being left behind in the new, fast-paced, changing world of health-care delivery.

But no one these days — doctors included — can afford to simply "retire" without putting some thought into it first. For years now, the American Medical Association (AMA) has been presenting advice-giving seminars to those entertaining thoughts of leaving practice. The seminars are called "Gearing Up for Retirement," and it's an apt name, assures Roy Loving. As part of the AMA's Department of Practice Management, Loving helps set up and speak at these retirement seminars. It's his job to get physicians thinking on the right track — before they begin to make retirement moves they may regret later.

Following is some of the advice he (and other experts) offer at the "Gearing Up for Retirement" seminars. If you are thinking about retiring — now, or even ten years down the road, you may want to take heed of the information offered here. It might keep *you* from making some costly retirement errors.

1. **Find something to retire to.** Probably five percent of the physicians who retire can be

classified as "retirement dropouts" — largely because they have found nothing to do with the 250 extra days they now face, says Loving. To avoid becoming a similar statistic, Loving urges retirees to evaluate their skills and aptitudes, and find something they would like to pursue, now that they have the time to do it. That can include a part-time medical practice; time spent as a medical claims reviewer; a position as cruise ship physician; or work for a locum tenens organization. Loving cautions physicians to check their liability responsibilities *before* making a firm commitment with any group, however. "It could be that you'll be responsible for your liability coverage, and the premium will be more than your payment." Other activities worth pursuing, says Loving, are the Elderhostel program (educational opportunities for those 60 years of age and over), and senior citizen organizations — "which offer excellent health and life insurance benefits in addition to their own scheduled activities," says Loving.

2. **Think before you relocate.** "Half of all physicians who move away move back to their original residencies within five years," says Loving. That's why it's a good idea to first *rent* in the area in which you intend to move — before you actually relocate permanently. "Experience the area in all seasons before you make a final decision," he adds. Subscribing to the community's newspaper will also give you a good glimpse of that area's politics, businesses and crime rates — allowing you to make a more informed decision. "If you decide to stay where you are, make sure you take care of major home improvements before you retire, so you can pay for them out of a full income. Major repairs should not come from a retirement nest egg," he warns. Those considering a move to a smaller home or condominium should also rent first, Loving suggests. "You may be in for a surprise if you've grown accustomed to your own private space."

3. **Get personal and financial affairs in order.** Starting too late, not accounting for inflation and not making plans which are sufficiently specific are the reasons many financial plans never hold up in retirement, Loving says. "If you're 60 or 70 years old, you should probably need 70 to 75 percent of your current net income to maintain your present lifestyle, so plan accordingly, he suggests — and "try to have loan installments and credit card balances 80 percent paid before retiring." Other tips: Check insurance policies as some change coverage when the policy holder reaches 65; request medicare's "Part B," which covers doctors' services; be sure malpractice insurance includes tail coverage; make a will; "and be sure you let your family know where all your policies and other important papers are."

4. **Consider selling your practice.** "This is becoming a very accepted procedure today," notes Loving. Since each practice is different, there is no set formula that can be used to determine a practice's worth, but equipment and supplies should be appraised at a fair market value, and a good rule of thumb in valuing the practice itself is to add up the accounts receivable for the last six months, and sell to the new doctor at 75 percent of the total face value, says Loving. Buyers for practices can be found through journals, placement services, hospitals, young physicians — even detail representatives.

5. **Know your legal responsibilities.** When you retire, decide whether or not you will maintain your medical license and, if you choose to keep it, keep current with your CME requirements and your liability payments, advises Brent Mulgrew, JD, deputy director of the OSMA, and Director of its Department of Legal Services. "You will need insurance coverage for the entire time you've been in practice," so make sure you purchase "tail" insurance before retiring. "And plan to maintain your medical records forever," he adds. Mulgrew also recommends physicians notify their patients in advance of their retirement. Proper notification, so that patients can locate another physician and accomplish smooth record exchanges, will not only leave little chance for "abandonment" suits, but will allow you, the physician, to sail right into the retirement you've been planning for. — *Karen S. Edwards*



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LEGISLATIVE REVIEW:

By the OSMA Department of Legislation

Introduction

January 1986 marks the halfway point of the 116th Ohio General Assembly. During the past twelve months, more than 150 individual pieces of legislation and numerous governmental administrative actions have been actively reviewed by the OSMA Department of Legislation. The OSMA has successfully impacted legislation and regulations that affect the physicians of Ohio and their commitment to cost effective quality health care for the citizens of Ohio.

Due to the critical elections of 1986, the second half of the 116th General Assembly is expected to be a short but intensive session. The races for Governor, Ohio Supreme Court, all other statewide offices, Congress, and the Ohio General Assembly will be the political highlights of 1986. However, the Ohio Legislature will be continuing its evaluation of many of the bills that the OSMA Department of Legislation monitored during 1985.

The priority legislative proposals that the OSMA Department of Legislation will be closely monitoring and impacting on in 1986 include: House Bill 494, requiring IPAs to contract with chiropractors, podiatrists, optometrists, dentists, and psychologists; House Bill 315, expansive revisions to the nurse practice act; House Bill 593, expanding the provider base and benefits for mandated mental health and alcoholism insurance benefit coverage; House Bill 536, granting psychologists hospital staff privileges; and H.B. 537, granting chiropractors hospital staff privileges; and House Bill 537, granting chiropractors hospital These are just a few of the 150 proposals being followed by the OSMA Department of Legislation in the 116th Ohio General Assembly. The following is an update of the major legislative proposals on which the OSMA Department of Legislation is actively working to represent Ohio physicians.

Any questions, requests for copies of the bills or OSMA analyses, please contact the OSMA Department of Legislation at OSMA headquarters in Columbus.

House Bill 494 threatens viability of IPAs

Immediate contacts with members of the Ohio Senate and particularly the members of the Senate Health, Human Services and Aging Committee are needed to indicate the strong opposition to House Bill 494 (Stinziano, D-Columbus). H.B. 494, if approved by the Senate, would dramatically affect the viability of Independent Practice Associations (IPAs) created throughout Ohio as a cost effective alternative health care delivery system to traditional health insurance coverage.

The legislation, which has been approved by the House of Representatives, would *require that IPAs offer provider contracts to chiropractors, podiatrists, optometrists, psychologists and dentists.* Although an IPA is a form of Health Maintenance Organizations (HMOs), H.B. 494, promoted by the chiropractors and other non-medical groups, would only affect the physician-supported IPA plans and not all HMOs. Regardless of the discriminatory nature of the bill, H.B. 494 mandates costly and unnecessary duplication of services by the IPAs which have received widespread acceptance from employers, employees and unions utilizing an IPA's current cost effective health care coverage. Action by physicians, auxilians, and all who are concerned with costly mandated benefits at the expense of cost containment, should begin immediately to indicate opposition to H.B. 494 through letters and personal contacts with the members of the Senate.

House Bill 494 would change Ohio's law to mandate the participation of non-medical practitioners (i.e. chiropractors) in Ohio's physician IPAs. These limited non-medical practitioners (chiropractors, podiatrists, optometrists, psychologists and dentists) currently have the ability to create their own plans and market them to employers and employees as the IPAs have done throughout Ohio.

H.B. 494 would also mandate that the IPAs "contain the cost of providing health care services" while offering contracts to chiropractors, podiatrists, optometrists, psychologists and dentists. This in itself would create a level of legal liability for the IPAs if costs increase. The duplication of services could be very costly. OSMA and individual physicians should contact employers and employees who utilize cost effective IPA services today to seek their assistance to thwart this effort by non-medical providers to threaten the viability of IPAs.

H.B. 494 ignores an essential element in an IPA's commercial viability, the ability to selectively contract with providers. Without this ability to selectively contract and to exercise strict utilization review of services provided by each practitioner, the IPA cannot effectively control its costs. This movement by the chiropractors and other supporters of H.B. 494 runs contrary to the national trend toward selectively contracting to hold down costs and is an effort by this group to economically benefit from the IPA's cost effective success in the marketplace.

Ohio's chiropractors and the other supporters of H.B. 494 have been working diligently during the Senate's holiday recess to prompt Senate action on the bill when the Senate reconvenes in January. It is imperative that physicians immediately contact their Senators, the Senate leadership and Senate Health Committee, and patients and colleagues regarding OSMA opposition to this legislative mandate. Letters to members of the Senate can be sent to the following address:

The Honorable _____
Ohio Senate
State House
Columbus, Ohio 43216

Dear Senator _____:

Members of the Ohio Senate include:

Leadership

President, Paul Gillmor (R-Port Clinton)
President Pro Tempore, Stanley Aronoff (R-Cincinnati)
Assistant President Pro Tempore, Paul Pfeifer (R-Bucyrus)
Majority Whip, Richard H. Finan (R-Cincinnati)
Minority Leader, Harry Meshel (D-Youngstown)
Assistant Minority Leader, Neal F. Zimmers (D-Dayton)
Minority Whip, Charles Butts (D-Cleveland)
Assistant Minority Whip, Thomas Carney (D-Girard)

Senate Health, Human Services and Aging Committee

David Hobson (R-Springfield), Chairman
Grace Drake (R-Solon), Vice Chairman
Scott Oelslager (R-North Canton)
Gary Suhadolnik (R-Parma Heights)
Charles Horn (R-Dayton)
Robert Burch (D-New Philadelphia)
Lee Fisher (D-Shaker Heights)
Richard Pfeiffer, Jr. (D-Columbus)
Marigene Valiquette (D-Toledo)

Other Senate members

Robert Boggs (D-Jefferson)
William Bowen (D-Cincinnati)
Eugene Branstool (D-Utica)
Oakley Collins (R-Ironton)
Robert Cupp (R-Lima)
M. Ben Gaeth (R-Defiance)
Theodore Gray (R-Columbus)
Donald Lukens (R-Middletown)
Robert Ney (R-Barnesville)
Oliver Ocasek (D-Northfield)
Marcus Roberto (D-Ravenna)
Cooper Synder (R-Hillsboro)
Richard Schafrath (R-Loudenville)
Eugene Watts (R-Columbus)
Michael White (D-Cleveland)
Alan Zaleski (D-Elyria)

Sub H.B. 315 — Revisions to the Nurse Practice Act

Version 3 of Sub. H.B. 315, which was offered in May, 1985, is still under consideration by the House Health Subcommittee. Although the Subcommittee has not met on the bill since July, 1985, Subcommittee meetings are expected to resume in January, 1986. Representatives of the Ohio State Medical Association, the Ohio Osteopathic Association, the Ohio Hospital Association, the Coalition for Revisions to the Nurse Practice Act, the Ohio Nurses Association, the Nurse Midwives and the Nurse Anesthetists met with Representative Judy Sheerer, the sponsor of Sub. H.B. 315, in October, 1985, to discuss provisions of this bill; however, as yet, no resolutions have been made regarding the OSMA's concerns with this bill.

As currently written, Version 3 of Sub. H.B. 315 would:

1. Authorize Advanced Practitioners of Nursing to prescribe controlled substances, dangerous drugs and devices under protocols agreed to by the Advanced Practitioner and a collaborating physician.

2. Defines the "direct provision of nursing care" to mean "the assessment, *nursing diagnosis,* implementation, and evaluation of health care needs for the purpose of maintaining health, preventing illness, and caring for the ill, injured, or infirmed." This definition applies to all registered nurses.

3. Defines "nursing diagnosis" to mean "determination of physical and psychosocial condition for the purpose of the effective execution and management of nursing care." This definition applies to all registered nurses.

4. Defines "nurse-midwifery" to mean "the independent management of normal newborns and women antepartally, intrapartally, postpartally, and gynecologically."

5. Create an eleven member Advanced Practice Council that would be authorized to advise the State Nursing Board and State Medical Board on "acts for which advanced practitioners of nursing are qualified . . . areas of overlap between medical practice and advanced practice of nursing . . . appropriate delegation and collaboration between physicians and advanced practitioners . . . model protocols for collaborative practice . . . means to provide better understanding between physicians and advanced practitioners . . . and other issues relating to the advanced practice of nursing."

6. Prohibit the State Medical Board from taking any action against an advanced practitioner of nursing or a physician involved in a collaborative practice with an advanced practitioner until the question has been submitted to the Advanced Practice Council and the Council has investigated the question, conducted a hearing, and issued an order.

7. Remove the current statutory provisions prohibiting nurses from performing "acts of medical, therapeutic, or corrective medical measures" and prohibiting nurses from engaging in the "practice of medicine or surgery or any of its branches." (ORC 4723.06, 4723.15 and 4723.33).

8. Remove the current statutory language that a nurse midwife practice "under the direction and supervision" of a physician (ORC 4731.33).

9. Establish that the Medical Practice Act does not apply to a person licensed, certified or registered under the Nurse Practice Act.

It should be noted that "supervision by a physician" is not included in Version 3 of Sub. H.B. 315; nor is the term "collaboration" or "collaborating physician" defined any place in the bill. The OSMA has a position of "strong opposition" to Sub. H.B. 315 — Version 3.

Physicians should contact their local State Representative and State Senator to inform them of the problems with Sub. H.B. 315 as currently drafted and indicate opposition to Sub. H.B. 315.

The OSMA Department of Legislation serves as the Association's eyes and ears of the physicians of Ohio in the Ohio General Assembly. The Department of Legislation is staffed by Richard A. Ayish, Director; Carolyn H. Towner; and Kent E. Studebaker, Associate Directors.

Rick Ayish returned to the OSMA in October 1985, after serving as a consultant for Public Affairs Management, Inc. representing physicians in contract negotiations and as liaison for the physicians with the county of Los Angeles, California. He formerly served as a staff person in the Ohio House of Representatives in 1976, the Associate Director for the OSMA's Department of State and Federal Legislation from 1976-1981, and as the Senior Director of Public Affairs for the Ohio Blue Cross and Blue Shield Plans from 1981-1984.

Carolyn H. Towner has been with the OSMA's Department of Legislation since September 1984. Ms. Towner was formerly the Executive Director for the General Assembly's Joint Committee on Agency Rule Review.

Kent E. Studebaker joined the staff of the Department of Legislation in January 1985. He formerly had served as the Legislative Assistant to Senator Richard H. Finan of Cincinnati since 1977. Prior to that, he served as a staff assistant for Senate Minority Leader Michael J. Maloney.

The OSMA Department of Legislation encourages individual physicians, physician groups, medical staffs and specialty societies to contact the Department on legislative issues and concerns. The Department of Legislation staff is available for legislative updates and briefings to these groups upon request. Contacts for information should be directed to the OSMA Department of Legislation at the OSMA headquarters in Columbus.



Agency Reference

To find the PICO agent(s) in your area, consult the listing below.

AKRON

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(216) 836-8866

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Youngstown, Ohio 44507
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Beachwood, Ohio 44122
(216) 464-4080

BOWLING GREEN

Bartlett Insurance Agency
121 East Court
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Wilder & Associates, Inc.
617 Vine Street
Cincinnati, Ohio 45202
(513) 721-1133

Thomas E. Wood, Inc.
1500 Carew Tower
Cincinnati, Ohio 45202
(513) 852-6339

CLEVELAND

Dennis Insurance Agency, Inc.
150 East Sprague Road
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Insurance benefits: Mental and emotional disorders, alcohol and chemical dependencies

Sponsored by Representative Jane Campbell (D-Cleveland), House Bill 593 would require health care benefit contracts, health insurance policies other than those covering specific diseases or accidents, and employee health care plans to cover mental and emotional disorders and alcoholism and chemical dependencies on "an equal basis with physical diseases" covered by the contracts, policies, or plans. The bill also requires that the coverage for mental and emotional illness and alcoholism and chemical dependency is to be undertaken by a plan of treatment that ensures the use of the most appropriate, least expensive services and includes adequate alternatives to inpatient care.

The services covered by the bill would include those offered by a licensed physician, licensed psychologist, licensed independent social worker, licensed professional counselor, or counselor (a licensed professional counselor or a member of the profession of alcoholism counseling or of drug abuse counseling, certified by the Department of Health or by an agency that the Department has recognized or credentialed to certify or credential such counselors).

The House Insurance Committee held initial hearings on the bill for both proponent and opponent testimony. The bill was referred to a subcommittee for further consideration.

Hospital access and privileges proposed for chiropractors

House Bill 537, sponsored by Representative Barbara Pringle (D-Cleveland), had initial hearings in the House of Representatives' Health and Retirement Committee during final days of the General Assembly's July calendar. This bill would require the "governing body of every hospital" to allow any licensed chiropractor "access to all outpatient diagnostic procedures offered by the hospital within the scope of the chiropractor's practice, by referral of any patient to the hospital on an outpatient basis, in the same manner as other licensed physicians refer patients to the hospital on an outpatient basis."

The bill would also prohibit the governing board of any hospital from discriminating against a chiropractor in considering and acting upon applications for staff membership or professional privileges within the scope of the applicant's license.

Further hearings have not been scheduled for this bill.

Hospital staff privileges for psychologists

Representative Edward J. Orlett (D-Dayton) sponsored H.B. 536 in the Ohio House of Representatives. This bill would prohibit the governing body of any hospital, in considering and acting upon applications for staff membership or professional privileges within the scope of the applicant's licensure, from discriminating against a psychologist solely on the basis of the person's practice of psychology.

The House Economic Affairs and Federal Relations Committee heard the sponsor's testimony during the Legislature's November session. Testimony presented to the committee by the Ohio Psychological Association stressed that the ability of a psychiatrist to utilize drugs in the treatment of a patient is the only major difference between a psychiatrist's scope of practice and a psychologist's scope of practice.

Other allied practitioner bills

Besides the Nurse Practice Act, three other allied practitioner licensure bills are currently pending before the General Assembly.

H.B. 570, sponsored by Representative Leroy Peterson (D-Maple Heights), would provide for the licensure of dietitians and would create a five member Board of Dietetics. This bill would prohibit the use of the title "dietitian" or "nutritionist" unless a person was licensed or exempt from licensure. A licensed physician acting within the scope of his/her profession would be exempt from dietitian licensure. A substitute bill is expected to be offered in January, 1986, which would include an exemption from licensure for a person when acting under the direction and supervision of a licensed physician in the execution of an order authorized by the physician. This bill is currently in the House of Representatives' Economic Development and Small Business Committee and has recently been undergoing hearings. Hearings are expected to resume in January, 1986.

Sub. H.B. 81, sponsored by Representative John Thompson (D-Cleveland), would license respiratory therapists and create a five member Ohio Respiratory Board. One member of the Board would be required to be a licensed physician. This bill was voted out of the House of Representatives' Health and Retirement Committee in March, 1985 and is pending in the House of Representatives' Rules Committee for scheduling for a floor vote.

H.B. 236, also sponsored by Representative John Thompson (D-Cleveland), would establish an eleven member Medical Radiation Technology Board within the Department of Health for the licensing of diagnostic radiologic technologists, nuclear medicine

technologists, and radiation therapy technologists. Licensed physicians and medical students would be exempt from licensure under this bill. This bill has been referred to the House of Representatives' Health and Retirement Committee.

Agency licensure and registration bills

The hospice licensure bill, sponsored by Senator Lee I. Fisher (D-Shaker Heights), passed the Ohio Senate by a vote of 31-0 on November 20, 1985. This bill, Sub. S.B. 22, was substituted while in the Senate Health, Human Services and Aging Committee and now would require licensure of a person or agency proposing to provide a hospice care program, instead of requiring licensure of all providers of hospice care. Sub. S.B. 22 was also amended to include the provision that "any hospital contracting for inpatient care shall be encouraged to offer temporary limited privileges to the hospice patient's attending physician while the hospice patient is receiving inpatient care from the hospital." This bill would also create a ten member Advisory Board for Hospice Care Programs with the Director of Health serving as a nonvoting ex-officio member of the Advisory Board. The bill would provide for a licensed physician with clinical experience in oncology or terminal illness to serve as a member of the Advisory Board. The bill will now be referred to a committee in the House of Representatives for hearings.

Representative Paul Jones (D-Ravenna) has introduced H.B. 715 which would require registration of every homemaker home health aide agency that receives public funds for homemaker home health aide services distributed by the Ohio Department of Aging, the Ohio Department of Health, the Ohio Department of Human Services, the Ohio Department of Mental Health, and the Ohio Department of Mental Retardation and Developmental Disabilities. This bill would require registration with each Department from which the agency receives public funds. H.B. 715 would also establish a Homemaker Home Health Aide Advisory Commission to evaluate homemaker home health aide services and to make recommendations to improve the quality of services provided. This bill has been referred to the Ohio House of Representatives' Health and Retirement Committee.

Seat Belt Bill awaits final legislative action

Amended Sub. S.B. 54, sponsored by Senator Paul Pfeifer (R-Bucyrus), was passed by the Ohio House of Representatives by a vote of 52-41 during the General Assembly's November session. This bill would require operators and front seat passengers of an automobile to wear occupant restraining devices when the automobile is in operation. A violation of this requirement would result in a possible $20 fine levied against the operator and a possible $10 fine levied against each non-complying front seat passenger. However, both the charge and the fine can be dismissed by the court if the violator proves to the court that he has viewed, prior to the court appearance, a seat belt education film prepared by the Ohio Department of Highway Safety. The films shall be prepared by the Department of Highway Safety's seat belt education program which will be funded from fines collected for the violations of this mandatory seat belt statute.

The bill also stipulates that the failure to wear an occupant restraining device "shall not be considered or used as evidence of negligence or contributory negligence, shall not diminish recovery for damages in any civil action involving the person arising from ownership, maintenance, or operation of an automobile, shall not be used as a basis for a criminal prosecution of the person other than for a prosecution for a violation" of the provisions of the bill and shall not be admissible as evidence in any civil or criminal action involving the person except for a violation of the mandatory seat belt requirement. This provision was strongly supported by the Ohio Academy of Trial Lawyers. Additionally, the bill stipulates that no law enforcement officer shall stop an automobile solely for a violation of the mandatory seat belt law.

Amended Sub. S.B. 54 has been returned to the Ohio Senate for concurrence with the House changes. It is anticipated that the Senate will accept the House changes when the legislature reconvenes in January. Governor Celeste has indicated he will sign a mandatory seat belt bill forwarded to him by the General Assembly.

Infectious Hazardous Waste/ Biomedical Waste Bill introduced

Senator Gary Suhadolnik (R-Parma Heights) has introduced legislation, S.B. 187, to govern the generation, treatment, storage, disposal of, and transportation of infectious hazardous waste and biomedical waste. This bill would require a generator of infectious hazardous waste or biomedical waste to ensure such waste be transported to a certified waste facility in a transporter registered with the Public Utilities Commission of Ohio. This bill would give the Public Health Council broad rule-making authority over infectious hazardous waste and biomedical waste, as well as over generators and transporters of such waste.

S.B. 187 would give local boards of health and the State Director of Health broad authority relative to inspections of waste facilities and the enforcement of waste standards. S.B. 187 has been referred to the Senate's Energy, Natural Resources and Environment Committee, which is chaired by Senator Suhadolnik. Senator Suhadolnik has indicated a willingness to work with the OSMA on the concerns of the OSMA with this bill.

Patient abuse legislation voted out of committee

House Bill 566, sponsored by Representative Jane Campbell (D-Cleveland), which concerns patient abuse and neglect was voted out of the Human Resources Committee on November 19, 1985. Prior to being voted out of committee, the bill as introduced was substituted with a new draft. Sub. H.B. 566 would establish criminal penalties for any person who owns, operates or administers, or who is an agent or employee of a care facility and "knowingly abuses" or "recklessly abuses" a resident or patient of the facility, and would establish "reckless neglect" as a misdemeanor of the first degree; however, a criminal penalty would apply to "reckless neglect" if the offender has been previously convicted of, or pleaded guilty to "reckless neglect." The bill would define "care facility" to include nursing homes, long-term care facilities, sheltered housing for older adults, and institutions or facilities operated by the Department of Mental Retardation and Developmental Disabilities.

The substitute bill would redefine "abuse" to mean "knowingly or recklessly causing physical harm or serious physical harm to a person by physical contact or by the inappropriate use of a physical or chemical restraint, medication, or isolation." This bill would redefine "neglect" to mean "the reckless failure to provide a person with any treatment, care, goods or service that is necessary to maintain the health or safety of the person and the failure results in physical harm or serious physical harm to the person." A provision was also included in the substitute version of H.B. 566 which provides "a person who relies upon treatment by spiritual means through prayer alone, in accordance with the tenets of a recognized religious denomination, shall not be considered neglected for that reason alone."

This bill now goes to the Rules Committee to be scheduled for a floor vote by the House of Representatives.

Corporal Punishment

Sub. Senate Bill 174, sponsored by Senator Oliver Ocasek (D-Northfield), would establish procedures, including reporting procedures, to be followed by a teacher, principal or administrator employed by a school who inflicts corporal punishment upon a pupil. This bill would require each school district to adopt procedures for notifying the parent, guardian or person in charge of the child when corporal punishment has been used as a disciplinary measure, and would require the superintendent or chief administrator to annually submit a corporal punishment summary to the State Board of Education for inclusion in a state report that would be made available to the public.

Sub. Senate Bill 174 passed the Senate on July 9, 1985. The bill has been referred to the House of Representatives' Education Committee.

Consolidated billing for health services

House Bill 540, sponsored by Representative Marc Guthrie (D-Newark), has been referred to the House of Representatives' Health and Retirement Committee. This bill would require providers of inpatient or outpatient health care services to a patient at a health care facility, i.e. hospital, urgent care center, or ambulatory surgery facility, to submit the initial bill for such services through the health care facility. The health care facility would then be responsible for submitting the patient a bill for all services provided at the facility.

Alzheimer's Disease

Senator David Hobson (R-Springfield) has introduced S.B. 256 which concerns Alzheimer's disease. The bill was referred to the Senate Health, Human Services and Aging Committee of which Senator Hobson is Chairman. The bill was substituted on November 19, 1985 in committee.

Sub. S.B. 256 would appropriate $1,850,000 for fiscal year 1986 to the Department of Aging for a grant program for Alzheimer's disease diagnostic and research and for the development of educational and support programs related to Alzheimer's disease. This bill would provide for the awarding of annual grants to enable schools of medicine or hospitals which are primary affiliates of a school of medicine to operate diagnostic and research centers for Alzheimer's disease and would provide for the awarding of annual grants to medical schools, hospitals which are primary affiliates of medical schools and other institutions for conducting research directed toward discovering the cause of and a cure for Alzheimer's disease.

Sub. S.B. 256 would also authorize the Director of Aging to develop training programs for health care personnel who participate or assist in the care or treatment of persons with Alzheimer's disease, to identify

groups which provide support for families of persons with Alzheimer's, and to administer pilot programs in respite care for persons with Alzheimer's disease. This bill would require the reporting of persons believed to have Alzheimer's disease to the Director of Aging.

Restrictions on use of animals for research

H.B. 296, which was introduced by Leroy Peterson (D-Maple Heights), has been under review recently by the House of Representatives' Agriculture and Natural Resources Committee. This bill would prohibit the use of animals for research, animal experimentation, testing, teaching or demonstration, unless the animal was specifically bred for such purposes. H.B. 296 would also require that any institution or organization that keeps animals for teaching and research purposes make the animals available for inspection, announced or unannounced, by agents of the Ohio Humane Society and county humane societies. Opponent hearings to this bill are expected in January, 1986.

Abortion Notification Bill passes General Assembly

The Ohio Senate, by a vote of 26-6, has passed Substitute House Bill 319 which would specify that before an abortion can be performed or induced upon an "unmarried, unemancipated" minor (under age 18), a reasonable attempt must be made (in most instances) to notify the minor's parents, guardian or custodian. The bill does not require parental consent.

The legislation would prohibit the performing of an abortion on a minor without first giving at least 24 hours actual notice in person or by telephone to the minor's parents, guardian or custodian, unless one of these persons has given written consent or a juvenile court has issued an order in lieu of parental consent.

The bill also provides that notification may be made to a specified stepparent, grandparent or sibling over 21 years of age instead of the minor's parents, guardian or custodian if there is both a request by the pregnant woman and a filing of affidavits with the appropriate juvenile court alleging the fear of abuse by the parent, guardian or custodian if they were to be notified. If actual notice cannot be given, a 48-hour period is designated to allow for notice by both certified and actual mail. Failing notification or if notification is made but the notified person does not wish to consult with the pregnant woman, the abortion may be undertaken.

The bill provides an affirmative defense for the person performing the abortion if the minor provides false or incorrect information about her age, marital status, emancipation, or the information required regarding the person to be notified; or, if the threat of serious risk to the life or physical health of the pregnant woman prevailed and necessitated the immediate performance of an abortion. Non-compliance with the notification provisions of the bill carry a penalty of a first degree misdemeanor.

The bill is now forwarded to Governor Celeste for action in any one of three ways: (1) sign the bill into law (2) allow the bill to become law within ten days without his signature or (3) a gubernatorial veto.

Living Will Legislation

The Senate Health, Human Services and Aging Committee has recommended Substitute H.B. 220 to the full Senate for consideration. This bill would establish procedures for making and implementing a "living will" in Ohio. A similar version of H.B. 220 had been passed in June, 1985 by the Ohio House of Representatives by a vote of 52-43.

The House bill provides immunity from civil and criminal liability or charges of unprofessional conduct for physicians and other health care professionals working under the physician's orders, for withholding or discontinuing medical measures from non-communicative terminal patients who have made living wills or directives as prescribed by the bill. These same conditions are also offered by H.B. 220 to instances where terminal patients who are permanently unconscious and have no living will but the patient's guardian, relatives or a court order permits the withholding or discontinuance of medical measures. Immunity is further extended to a physician for failure or refusal to comply with the terms of a directive or a living will, but requires that a physician under such conditions shall not prevent the transfer of the patient to another physician or facility.

A Senate vote on this bill may be scheduled when the Senate reconvenes in January, 1986.

Insurance Fraud

S.B. 18 (Eugene Branstool, D-Utica) is an insurance fraud bill, proposed by Blue Cross of Northern Ohio, which would raise the penalty for medical insurance fraud from a misdemeanor to a felony for fraudulent claims under $300.

The bill was extensively reviewed by a subcommittee of the Ohio House Insurance Committee and a substitute version was recommended back to the full Insurance Committee. The bill will most likely be recommended for passage by the committee following a brief review of the substitute version. During the subcommittee hearings, OSMA legal counsel provided the subcommittee with technical

assistance regarding legal standards being established by the bill.

Bills affecting coroners introduced

Two bills have been recently introduced which would affect coroners. House Bill 726, sponsored by Representative Joan Lawrence (R-Galena), would require an autopsy of a child when a child under the age of one and in apparent health dies suddenly. This bill would establish reporting requirements regarding the preliminary and final results of the autopsy and would provide that the cost of the autopsy, not to exceed $400.00, be paid by the Ohio Department of Health. This bill has been referred to the Ohio House of Representatives' Finance and Appropriations Committee.

Senate Bill 283 has been introduced by Senator Stanley J. Aronoff (R-Cincinnati). This bill would place certain limitations on the power of the county coroner to perform an autopsy if a relative or friend of the deceased person informs the county coroner that an autopsy is contrary to the deceased's religious beliefs, or if the coroner otherwise has reason to believe an autopsy is contrary to the deceased's religious beliefs. This bill would establish procedures to be followed when the coroner concludes the autopsy is a compelling public necessity, or when the coroner concludes the autopsy is necessary, and the autopsy is contrary to the deceased's religious beliefs. This bill has been referred to the Senate State and Local Government Committee.

Alternative treatments for breast cancer

House Bill 415, sponsored by Representative Francine Panehal (D-Cleveland), has been referred to the House of Representatives' Health and Retirement Committee. This bill would require the Director of the Department of Health to appoint a Cancer Treatment Advisory Committee to assist the Department in developing standardized written summaries describing the "alternative efficacious methods of treatment of breast cancer that may be medically viable." This bill would also require the physician to provide the patient with a copy of the standardized written summary appropriate to the patient's medical condition and to explain the treatment options appropriate to the patient's medical condition. H.B. 415 would also mandate a consent form to be executed prior to a physician or surgeon operating on a patient for a tumor of the breast.

AIDS Bill introduced

State Representative Don Gilmore (R-Columbus) has introduced H.B. 704, which would establish the disease of Acquired Immune Deficiency Syndrome (AIDS) as a contagious disease. This bill would require health care professionals to report the existence of a person suffering AIDS to the local board of health and would require the local board of health to order the isolation of such patient until the patient has recovered and is no longer liable to communicate the disease to others. H.B. 704 would prohibit AIDS victims from attending school until released from isolation, but would mandate the school district to ensure the child receives the required educational instruction through tutoring.

Representative Gilmore indicated that he introduced H.B. 704 to stimulate research and the legislative review of this issue that is gaining attention nationwide. This bill has been referred to the House of Representatives' Health and Retirement Committee.

Physician-Patient Communications

Representative Ronald J. Suster (D-Cleveland) has introduced H.B. 457, which would provide an exception to the privileged communication made to a physician by his patient. This bill would provide that "the physician may be compelled to testify with respect to any information communicated to him by a patient in an effort by the patient to unlawfully procure a controlled substance . . . or a dangerous drug . . . or to unlawfully procure the administration of a controlled substance or dangerous drug." This provision would enable a physician to testify in a court case to prove that a patient had lied to the physician in an attempt to obtain drugs. This bill would also increase the penalties for violation of deception to obtain drugs. H.B. 457 has recently been undergoing hearings in the House of Representatives' Judiciary and Criminal Justice Committee. Hearings are expected to resume in January, 1986.

Hospital Data Collection

House Bill 533 (R. Miller, D-Columbus) is aimed at establishing a system where the Ohio Department of Health can collect data on hospital costs and patient discharge information. As currently written, H.B. 533 would mandate hospital reporting by requiring hospitals to release their UB-82 forms, i.e., the hospital billing forms, to the Department of Health. The Department would then create a data base which could be used to create hospital-specific information on average room costs, length of stay (LOS), the costs of ancillary services, and cost/DRG. Although information would not be reported on a physician-specific basis, the physician identifiers would appear on the UB-82 as submitted.

Several meetings have been held to discuss alternative legislation. A likely substitute bill would involve

data disclosure instead of data reporting. Under data disclosure, each hospital would be responsible for compiling its own data summary for each specified DRG. Data might include such information as average LOS, the average charges, age categories, sex, category of bed. This composite information developed by each hospital would then be reported in a uniform fashion to the Department of Health.

It is important to note, though, that there has been no agreement reached on the data disclosure proposal. It is merely on the table for discussion. H.B. 533 remains in the House Health and Retirement Committee.

A data bill, S.B. 288, sponsored by Senator Robert Ney (R-Barnesville), was introduced in the Senate in the November session, but, to date, no action has been taken on this bill.

Child and Adult Abuse and Neglect Legislation

Representative Vernon L. Sykes (D-Akron) has introduced six bills concerning child abuse and neglect. H.B. 349 would raise the penalty for child abuse involving serious harm. This bill passed the House of Representatives on May 8, 1985 by a vote of 96-0 and passed the Senate on November 19, 1985 by a vote of 32-0. H.B. 349 is awaiting the signature of the Governor. A similar bill, S.B. 160, sponsored by Senator Thomas Carney (D-Youngstown), has been referred to the Senate's Judiciary Committee.

Representative Sykes has also introduced H.B.'s 528 through 532. H.B. 528 would require school employees to report suspected child abuse and neglect. This bill passed the House of Representatives on June 26, 1985 by a vote of 89-3, was voted out of the Senate's Education and Retirement Committee, and is currently pending in the Senate Rules Committee awaiting scheduling for a Senate floor vote.

H.B. 529 would clarify when a person must report child abuse or neglect. This bill passed the House of Representatives on November 19, 1985 by a vote of 87-5. This bill will now be referred to a Senate Committee for hearings.

H.B. 530 would require that a physician in a hospital or institution report suspected child abuse or neglect, instead of reporting it to the person in charge of the institution or hospital and having the person in charge make the report. This bill was voted out of the House of Representatives' Children and Youth Committee in November, has been referred to the Rules Committee, and is awaiting scheduling for a floor vote in the House.

H.B. 531 would broaden the applicability of the provision that any person required to report child abuse or neglect information do so notwithstanding the fact that the information may otherwise be privileged to apply to attorneys, clergymen, school guidance counselors and psychologists, as well as physicians. H.B. 532 would make negligence the culpable mental state for failure to report child abuse or neglect when required to do so. Both H.B. 531 and H.B. 532 were originally referred to the House of Representatives' Children and Youth Committee, but have since been sent back to the Reference Committee for re-referral to the House of Representatives' Judiciary and Criminal Justice Committee.

Representative Paul Jones (D-Ravenna) has introduced H.B.'s 66, 75 and 79 which concern abuse and neglect. Sub H.B. 66 would expand the list of individuals required to report suspected abuse, neglect or exploitation of adults, including mentally retarded and developmentally disabled adults. This bill passed the House of Representatives on March 13, 1985 by a vote of 86-7 and passed the Senate 32-0 on November 19, 1985. Sub. H.B. 66 is awaiting the signature of the Governor.

H.B. 79 would attempt to centralize information and establish a statewide toll-free telephone number that may be called for information pertaining to child, elderly or spouse abuse or neglect, abuse of mentally retarded persons or incest. H.B. 75 would require the court to consider the existence of abuse or neglect in a household when determining child custody and visitation, and would require counseling before reuniting children with their families if abuse or neglect is or was present. H.B.'s 75 and 79 have been referred to the House of Representatives' Children and Youth Committee.

Restrictions on clove cigarettes and smoking; warning labels on snuff containers

A number of bills have been introduced this session prohibiting the sale and possession of clove cigarettes, placing prohibitions on smoking, and requiring a warning label on snuff containers.

H.B. 596 (Miller, D-Columbus) and the companion S.B. 213 (Branstool, D-Utica) would prohibit the sale, possession for sale, the manufacture, and the possession or use of any cigarette or tobacco product that contains cloves, clove oil, or eugenol. H.B. 599 (Gilmore, R-Columbus) would prohibit giving, selling or otherwise distributing clove cigarettes to any person. H.B. 596 and H.B. 599 have been referred to the House of Representatives' Health and Retirement Committee. S.B. 213 has been referred to the Senate's Health, Human Services and Aging Committee.

Representative Ike Thompson (D-Cleveland) has introduced three bills dealing with smoking and cigarettes. H.B. 282 would

prohibit persons from possessing any lighted smoking material in a place of public assembly, except in a designated smoking area. A place of public assembly would include, but not be limited to, health care facilities, nursing or rest homes, retail establishments, banks, commercial establishments, public restrooms, elevators, places of public or private employment, or enclosed places of entertainment or recreation. This bill has been referred to the House of Representatives' State Government Committee.

H.B. 330 (Thompson, D-Cleveland), would prohibit a manufacturer, producer, distributor, wholesaler, or retailer of cigarettes or other tobacco products from giving away sample packages of cigarettes or other tobacco products and would restrict the advertising of cigarettes or other tobacco products. After hearings in the House of Representatives' State Government Committee, this bill was placed in a subcommittee.

H.B. 78 (Thompson, D-Cleveland) would increase the state cigarette tax by five cents per pack to fund cancer research and treatment. This bill has been referred to the House of Representatives' Ways and Means Committee.

Senator Charles Horn (R-Dayton) has introduced S.B. 280, which would allow a municipal corporation, county or township to pass an ordinance to regulate smoking in places of public assembly in a more restrictive manner than is currently required by state law. This bill has been referred to the Senate State and Local Government Committee.

House Bill 670 has been introduced by Representative Ronald Gerberry (D-Youngstown) and House Bill 679 has been introduced by Representative Ray Miller (D-Columbus) to require a warning label to be placed on packages or containers of snuff. The required warning label would state: "WARNING: Use of snuff can be addictive and can cause mouth cancer and other mouth disorders." Both bills have been referred to the House of Representatives' Health and Retirement Committee.

Medically Handicapped Children's Program

State Representative Jolynn Boster (D-Gallipolis) has introduced H.B. 614. This bill would change the name of the "Crippled Children's Services" program to that of the "Medically Handicapped Children's" program. H.B. 614 would set forth the authority of the Public Health Council to adopt rules for this program and would establish the authority of the Department of Health to develop a manual of operational procedures and guidelines for the program. This bill would establish the responsibilities of the Department of Health relative to the administration of Title V of the Social Security Act and the administration of the Medically Handicapped Children's program. This bill is very similar to current law, except that: 1) it no longer provides for the payment of actual travel expenses of the child and of any agent of the Bureau of Crippled Children's Services in whose charge the child travels; 2) it no longer provides for visits to children accepted for treatment by a Bureau representative; 3) it no longer provides for termination of any contract for the care and treatment of a child when the Bureau determines that such action is justified; 4) it no longer provides services to persons 21 years of age or older suffering from sickle cell anemia; and 5) all current responsibilities of the Bureau of Crippled Children's Services would be placed with the Department of Health. The current funding by each county for treatment services would remain the same under this program as it is in the Crippled Children's Services program.

H.B. 614 would also amend current statutory language to: 1) change the name of the "Crippled Children's Services Medical Advisory Committee" to the "Medically Handicapped Children's Medical Advisory Committee"; 2) to set forth the committee shall advise the Director of Health regarding the administration of this program, the "suitable quality of medical practice for providers," and on the medical eligibility for the program; 3) to change the "Crippled Children's Services Advisory Committee" to the "Maternal and Child Health Consultants' Group"; and 4) to limit the reimbursement to Committee or Group members to "travel" expenses.

This bill has been referred to the House of Representatives' Health and Retirement Committee.

Medical Records for Nursing Homes

Representative Barbara Pringle (D-Cleveland) has introduced legislation that would allow a patient or person in interest to examine or obtain a copy of a medical record covering the patient's prior residency in a nursing home. House Bill 691 would provide that if a physician determines "for clearly stated reasons" that disclosure of a record is likely to have an adverse effect on the patient, the home shall provide the record to a physician designated by the patient. H.B. 691 has been referred to the House of Representatives' Human Resources Committee.

Bill to provide civil immunity to chiropractic peer review committee introduced

Senator Stanley Aronoff (R-Cincinnati) introduced Senate Bill

186 which would grant limited civil immunity to members or employees of a non-profit corporation acting as a peer review or professional standards review committee of a state or local chiropractic organization. This liability is currently granted by state statute to a peer review or professional standards review committee composed of chiropractors of a state or local chiropractic organization. The bill would also extend civil immunity to persons providing information to the committee.

The bill had its first hearing before the Senate Health, Human Services and Aging Committee during the Legislature's brief November session. Additional hearings are anticipated when the Senate reconvenes in January of 1986.

Artificial Insemination

H.B. 476 has been introduced by State Representative Marie Tansey (R-Vermilion). This bill was substituted in the House of Representatives' Judiciary and Criminal Justice Committee in November and would establish the requirements for the non-spousal artificial insemination for the purpose of impregnating a woman so that she can bear a child that she intends to raise as her child. Sub. H.B. 476 specifically does not deal with the artificial insemination of a wife with the semen of her husband or with surrogate motherhood. The bill would require that if a wife is artificially inseminated with semen from a man who is not her husband, "the husband shall be treated in law and regarded as the natural father of a child conceived as a result of artificial insemination, and a child so conceived shall be treated in law and regarded as the natural child of the husband." The donor of the semen would not be treated in law or regarded as the natural father of the child.

The purpose of H.B. 476, according to the proponents of this bill, is that the current Ohio Parentage Act does not address children conceived through artificial insemination; thus, the parentage of these children could be interpreted to be subject to determination under the general provisions relative to biological parentage. In an action under Ohio's Parentage Act, the medical records and physician's testimony regarding the pregnancy and birth are available to the child, alleged father and to the mother, and proponents of the bill fear records concerning an artificial insemination may not be privileged.

Sub. H.B. 476 was voted out of the House of Representatives' Judiciary and Criminal Justice Committee on November 20, 1985. This bill is presently in the Rules Committee awaiting scheduling for a vote by the House of Representatives.

OSMA's Legislative staff consists of: Rick Ayish, Director; Kent Studebaker; and Carolyn Towner.

Trustee of charity

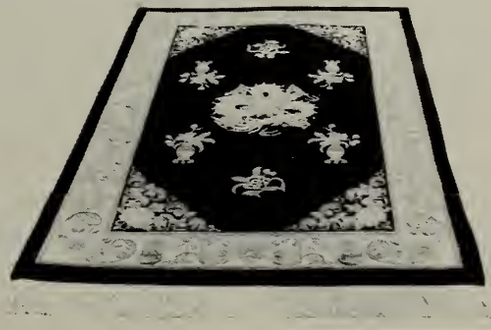
KARL S. ALFRED, MD, Cleveland, has been honored by the Greater Cleveland Hospital Association's Center for Health Affairs for his "leadership and dedication" as a trustee of charity. Dr. Alfred has been a trustee for the association for 12 years.

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It used to be that kidney stone sufferers faced great pain, surgery, a week or two in the hospital, and six to 10 weeks of recovery.

Not anymore. With today's technology, kidney stones can be removed without surgery and with virtually no pain.

In January, a new form of treatment called Extracorporeal Shock Wave Lithotripsy (ESWL) will be available in Columbus on campus at Riverside Methodist Hospital. The new procedure uses shock waves to disintegrate kidney stones without affecting other tissues. Use of the lithotripter reduces days in the hospital, loss of work time and health care dollars.

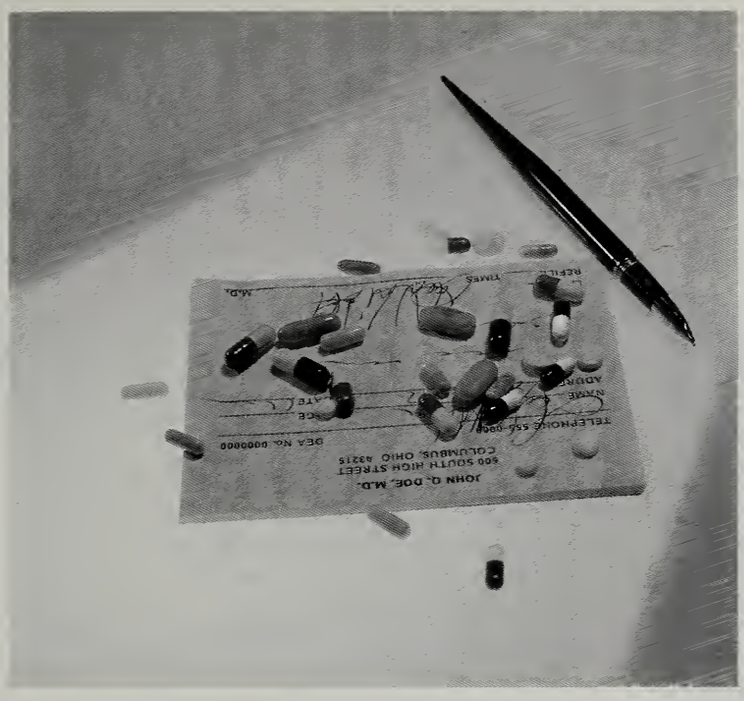
Central Ohio's lithotripter will be housed in the state's first free-standing center being built by central Ohio urologists.

For more information, call the Ohio Kidney Stone Center (614) 457–1038, 8 a.m. to 5 p.m. weekdays. If outside central Ohio, call collect.

OHIO KIDNEY STONE CENTER



3525 Olentangy River Road, Columbus, Ohio 43214



PADS:

A Look at Prescription Drug Abuse

In early December the Ohio State Medical Association presented Governor Richard Celeste with eight recommendations which could drastically reduce the prescription drug diversion problem in the state.

These recommendations were the result of a six-month study conducted by the OSMA and 23 other professional groups, state agencies and boards. The Project, Prescription Abuse Data Synthesis or PADS, was developed and funded by the American Medical Association who supplied a consultant, Barry Rhodes of Applied Resources Corporation, to serve as a technical advisor to the project.

Herman I. Abromowitz, MD, President of the OSMA, said at the special news conference held to unveil the project: "It is incumbent on the profession of medicine to take the initiative in solving this problem. Virtually all health care practitioners are concerned, caring professionals who put the best interest of their patients first. This program was developed and implemented to remove from practice those who do not."

Approximately 1.5 billion prescription drugs are dispensed in the U.S. each year. Of those, several hundred million dosage units are diverted from normal and legal distribution points to illicit use. According to federal government reports, abuse of prescription drugs results in more injuries and deaths to Americans than all illicit drugs combined. Prescription drugs are involved in almost 60% of all drug-related emergency room visits and 70% of all drug-related deaths.

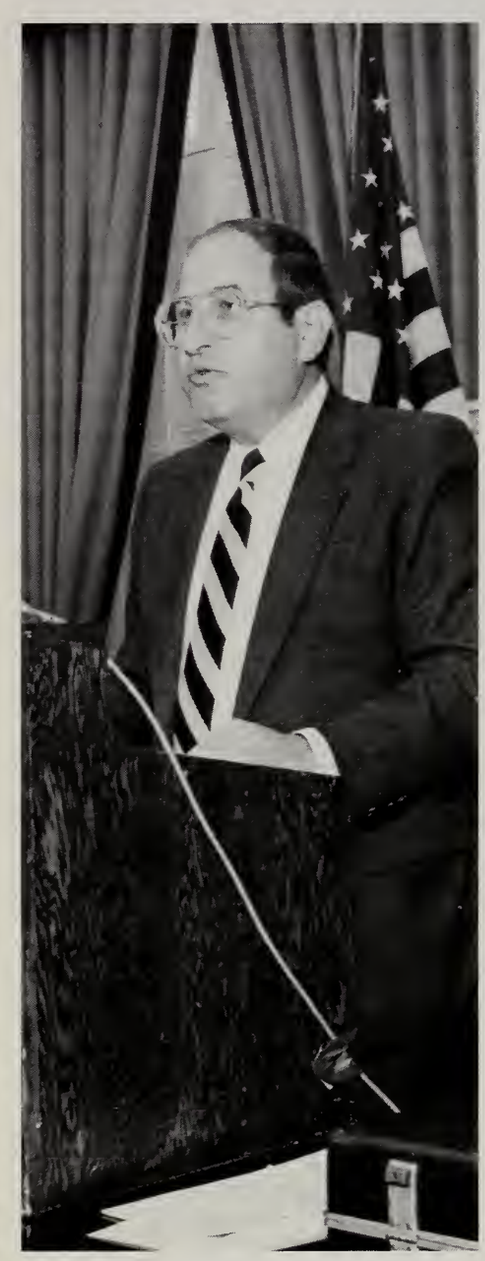
The AMA developed the PADS project to identify sources of prescription drug diversion within the state and to formulate solutions to the problem.

The AMA designed PADS for use at the state level because the nature of prescription drug abuse varies dramatically from state to state and data to identify the problem and mechanisms to resolve it are concentrated at the state level.

In February of 1985, in recognition of the growing problem of prescription drug diversion in the state, the OSMA officially requested the AMA to conduct PADS in Ohio. Thus far,

PADS: A Look at Prescription Drug Abuse

continued



Herman I. Abromowitz, MD, OSMA President

All organizations which have any connection to prescription drugs are asked to participate.

the AMA has conducted PADS in 20 states.

According to Harrison L. Rogers, MD, President of the AMA, who also spoke at the special news conference: "PADS is a program we are very proud of at the AMA. It is tangible evidence that physicians and other health care professionals are deeply committed to protecting and preserving high quality health care. It is also an excellent example of how much can be accomplished when public and private agencies work together with a common goal."

The premise behind PADS is fairly simple: All organizations, boards and agencies, public and private, within a state, which have any connection to prescription drugs and/or the people who have a license to dispense them are asked to take part in the project. Representatives of these groups meet and, utilizing existing data to which each group has access, examine the drug diversion problem within a state.

Generally, the PADS group is divided into three subcommittees with separate responsibilities:

- The Technical Group — gathers information on data collection and analysis capabilities in the state;
- Regulatory/Enforcement Group — coordinates the targeting of specific cases and the investigative activities which involve the sharing of confidential information;
- Professional Association Group — coordinates the activities of the health professional organizations in areas such as education and impairment programs.

All findings are reported to and coordinated by the umbrella group — The PADS Policy Group. By analyzing the finding of each subcommittee, the policy group is able to draw up recommendations to alleviate the problem.

In Ohio, after a six-month study, the PADS Group found: the distribution of methamphetamine to Ohio is more than four times the national average; the distribution of amphetamine is more than 2.5 times the national average (and in some areas of the state 16 times the national average); the distribution of methaqualone (prior to being removed from the market due to excessive use) was just under twice the national average.

In addition, a special study in seven metropolitan centers in the state indicated that prescription opiates (including Dilaudid) resulted in more drug abuse treatment center admissions than the drugs heroin, marijuana and cocaine combined.

Further, the PADS Policy Group found that although drugs are diverted at numerous points in the production and distribution chain, in Ohio 80% to 90% of such diversions occur at the hospital, practitioner and community pharmacy level.

PADS classified the practitioners who are involved in drug diversion into four major categories:

Dishonest — or "script" — health care professionals who willfully and knowingly prescribe and/or dispense drugs for purposes of abuse and, usually, for profit, and pharmacists who willingly and knowingly dispense drugs pursuant to false or forged prescriptions or dispense drugs of abuse without a prescription.

Disabled — or impaired — health care professionals whose professional competence has been impaired by drug abuse, alcoholism, or other physical or mental disorders.

Duped practitioners and pharmacists who unwittingly contribute to the problem by acquiescing to some patients' ruses or insistent demands for drugs of abuse or pharmacists who dispense drugs of abuse pursuant to forged

or false prescriptions.

Dated health care professionals who have not kept pace with developments in pharmacology, drug therapy or the abuse of drugs.

In Ohio, the PADS Policy Group was able to identify many problems in the existing systems and made recommendations to address those problems.

PROBLEMS AND RECOMMENDATIONS

Lack of Interagency Cooperation

According to the PADS group, in Ohio the decentralization of drug enforcement activities has been a major hurdle to the successful prosecution of drug diversion cases. Although many state boards and agencies have investigated the same cases as federal and local enforcement personnel, to date there has been no cohesive approach to information sharing and investigation.

The PADS Policy Group directed two sets of activities designed to improve this situation. The technical group provided and analyzed data from more than a dozen separate sources, identifying those prescription drugs most subject to abuse and diversion; then the regulatory/enforcement group formed teams of federal, state and local enforcement officials to investigate targeted cases.

In its final report, PADS recommended that the Governor formally establish by executive order the PADS Policy Group and that the group continue to work cooperatively in collecting and analyzing data and in investigating prescription drug abuse cases.

Statutory Impediments to Investigations

The Policy Group identified many statutory provisions which impeded the investigation and prosecution of drug diversion cases. Three major areas that concerned the committee were:

- Inadequate Amphetamine controls.
- Inability to quickly remove identified drug diverting practitioners from practice.
- The ineffective disposition of prescription drug abuse cases.

As a class, amphetamines are the most abused of all prescription drugs in Ohio. In some sections of the state, amphetamine distribution is 16 times the national average. Given the fact that there is limited therapeutic value and high abuse potential for amphetamines, the Policy Group felt it was necessary to restrict amphetamine distribution to those few instances where there is a medically indicated condition warranting its use. Therefore, they recommended that the governor support regulations, proposed by the Ohio State Medical Board, which would limit the indications for the prescribing, dispensing and administration of schedule II stimulants.

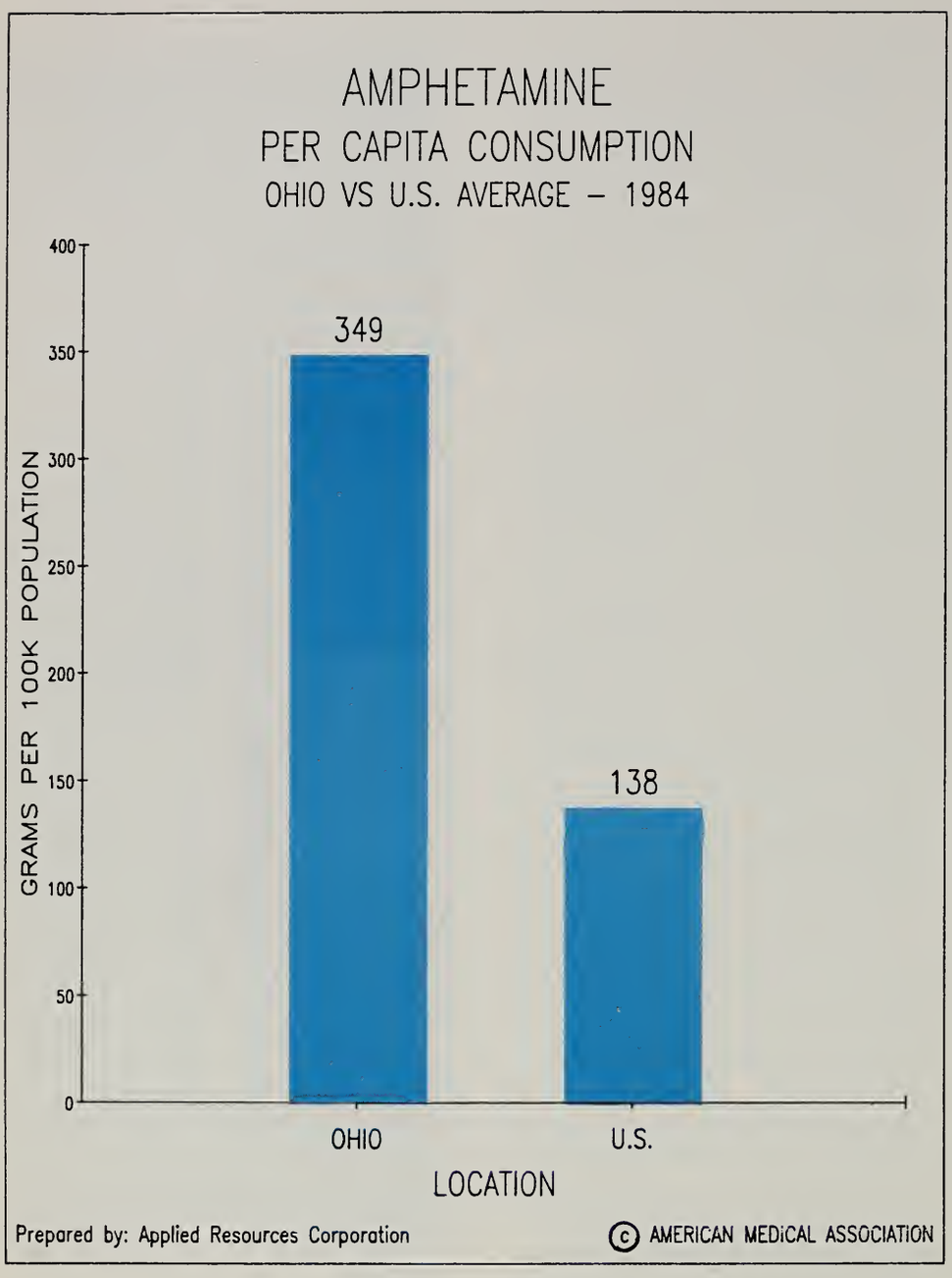
Another significant problem is the inability to quickly remove identified drug-diverting physicians from practice. Now (except by court order) a physician cannot be barred from practice until there has been a full administrative hearing which can take months, or sometimes years. The PADS group recommended in its report that the Governor support legislative efforts to grant the Ohio State Medical Board the authority to summarily suspend the license of a practitioner prior to a full administrative hearing if it has been shown that the physician is an imminent danger to the public by reason of his/her diversion activities.

Other significant problems were raised regarding deficiencies in the drug statutes which impeded the prosecution of drug cases. Because of the number of problems and the need to coordinate statutory changes, the Policy Group determined a comprehensive review should be undertaken to identify those statutes which need



Harrison L. Rogers, MD, AMA President

"PADS is a program we are very proud of at the AMA . . ."



to be revised. The group's recommendation: the governor direct the PADS Policy Group to review Ohio statutes and to report to the Governor by July 1, 1986 those legislative and regulatory changes which would facilitate appropriate disposition of prescription drug abuse cases.

Lack of Public Education

The Policy Group determined that the scope of the prescription drug abuse problem in Ohio must be attacked by an overall coordinated approach to inform the public and the professions of the extent of the problem.

Information and education programs, targeted to health care practitioners and focused on the nature and extent of prescription drug abuse in Ohio, are being developed by the group and they recommend: the Governor direct appropriate state agencies to collect and disseminate information regarding the scope and magnitude of the prescription drug abuse problem in Ohio.

Since it is also recognized that as the supply of diverted prescription drugs declines, there will be an increased demand for treatment, the group is also recommending that the Governor encourage the allocation of additional resources for abuse demand reduction. Resources allocated should address treatment and prevention.

Other information developed by the group demonstrated that:

- There was no uniform approach to the treatment of impaired professionals by the various state licensing boards.
- Language regarding impairment was inconsistent among the professional licensing statutes in Ohio.
- The various professional association's impaired programs had significant differences in the structure of the programs and the standards used.
- There was minimal formal dialogue between the licensing boards and the professional

associations on issues of impairment.

Given these problems, the associations decided it was necessary to discuss impairment issues directly with the licensing boards. Representatives of the various associations' impairment programs and licensing boards met and agreed to work together to develop legislation on impairment for all the professions participating in PADS. It was agreed that any legislation or guidelines developed must adequately insure the protection of the public.

The Policy Group affirmed that a forum for the licensing boards and associations is a necessary element in addressing problems of drug diversion related to impairment, and they recommended the Governor support the establishment of a joint commission consisting of a representative from each health care licensing board and each health care professional association involved in the PADS program. This commission would be responsible for: 1) approval of each association's impaired professional program as an acceptable method of impairment intervention; 2) board and association interaction on issues of impairment.

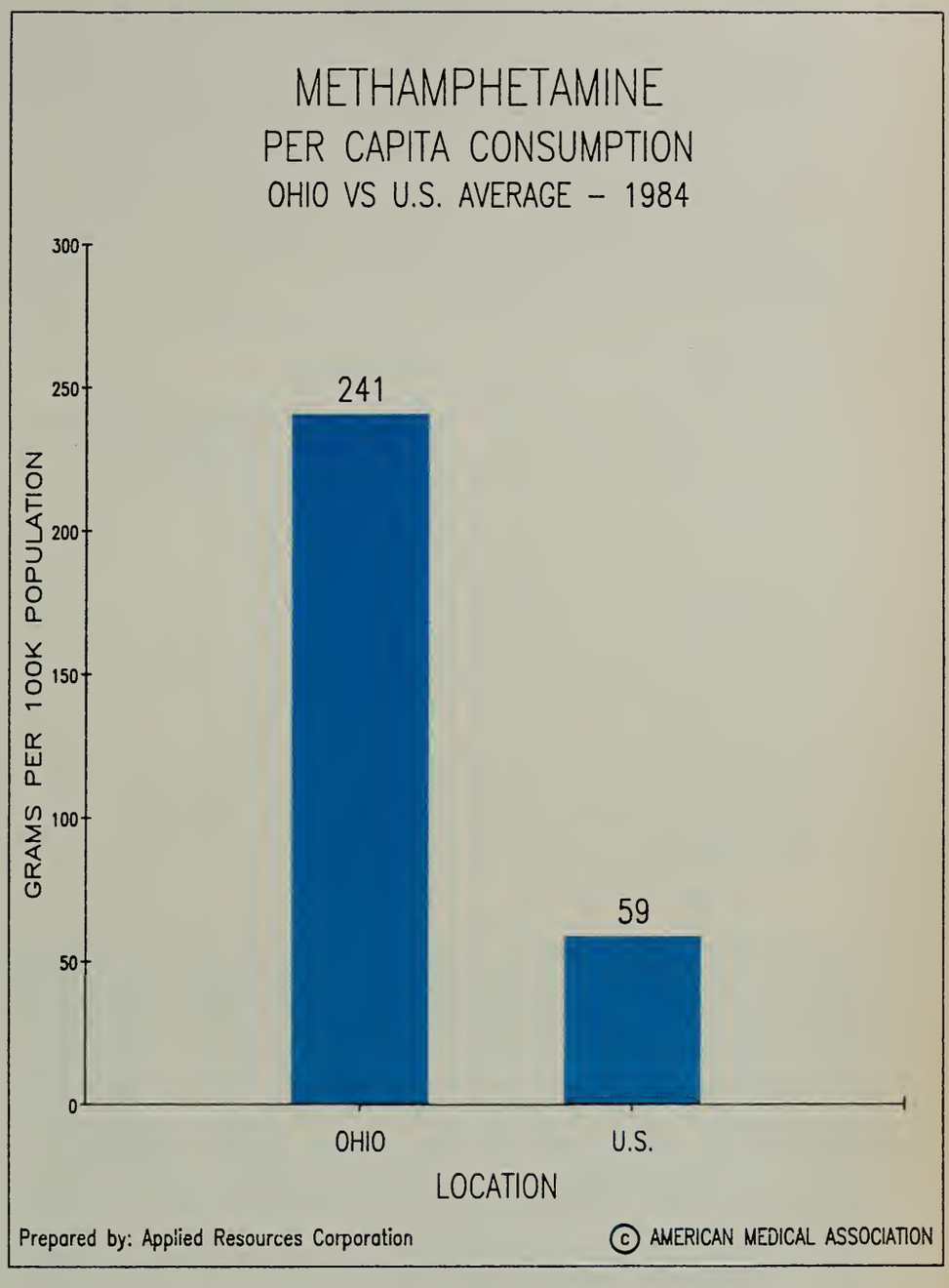
Limited Investigative Resources

An inventory of investigative resources available for drug cases at the state and federal level in Ohio revealed several limitations.

- board investigators with multiple responsibilities.
- investigators whose jurisdiction is limited by geography and authority.
- inadequately trained investigators.

An interagency agreement was developed which provides for: 1) investigative teams, based on authority and jurisdiction 2) training in investigative techniques for both the criminal and administrative code.

Another major problem is the



Agencies involved with PADS

Bureau of Alcohol Abuse and Alcoholism Recovery
Bureau of Drug Abuse
Federal Drug Enforcement Administration
Industrial Commission of Ohio
Ohio Association of Chiefs of Police
Ohio Attorney General's Office (including Bureau of Criminal Information & Investigation)
Ohio Board of Nursing Education & Nurse Registration
Ohio Dental Association
Ohio Department of Health
Ohio Department of Human Services
Ohio Hospital Association
Ohio Nurses Association
Ohio Osteopathic Association
Ohio Pharmaceutical Association
Ohio Podiatric Medical Association
Ohio Prosecuting Attorneys Association
Ohio Sheriffs Association
Ohio Society of Hospital Pharmacists
Ohio State Board of Pharmacy
Ohio State Dental Board
Ohio State Highway Patrol
Ohio State Medical Association
Ohio State Medical Board
Ohio Veterinary Medical Association
Ohio Veterinary Medical Board

lack of qualified expert witnesses to testify in drug diversion cases. Although a case may be adequately investigated, a prosecution will not be successful unless there is an expert who can testify that there has been a deviation from accepted medical practice. The group recommended that the state allocate sufficient resources for adequate training, staffing, and compensation for investigators, attorneys and expert witnesses dealing with drug diversion cases.

"These recommendations are an excellent first step. . . ."

All of the PADS recommendations were turned over to the Governor for his consideration and the PADS group is confident he will act upon its recommendations soon.

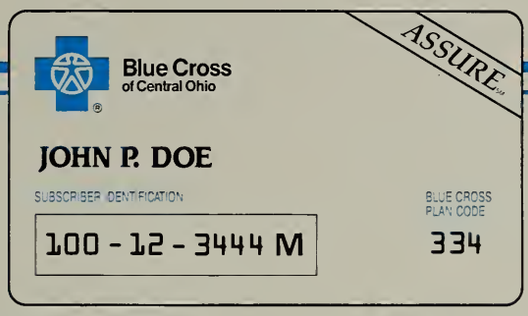
If the first PADS recommendation is accepted — that the Governor formalize the existence of the group — the PADS members will continue to meet further to study the problem.

As Dr. Rogers said at the PADS Press Conference: "Taken separately, none of these recommendations will stop the flow of prescription drugs as soon or as completely as any of us would hope. However, these recommendations are an excellent first step in seeing the problem addressed. By working collectively, the various boards and agencies involved in PADS were able to gather more drug diversion data than ever before. By continuing to work collectively, we can virtually eliminate the problem of drug diversion." **OSMA**



Presenting the PADS report to Governor Richard Celeste (second from left) are: Harrison L. Rogers, MD, (far right) David Jackson, MD, and Herman I. Abromowitz, MD (with back to camera). Paul Coleman (far left) is Director of Recovery Services.

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Can hospitals require their medical staffs to carry a mandated amount of liability protection? Since mid-November, that not-so-simple inquiry has become . . .

The



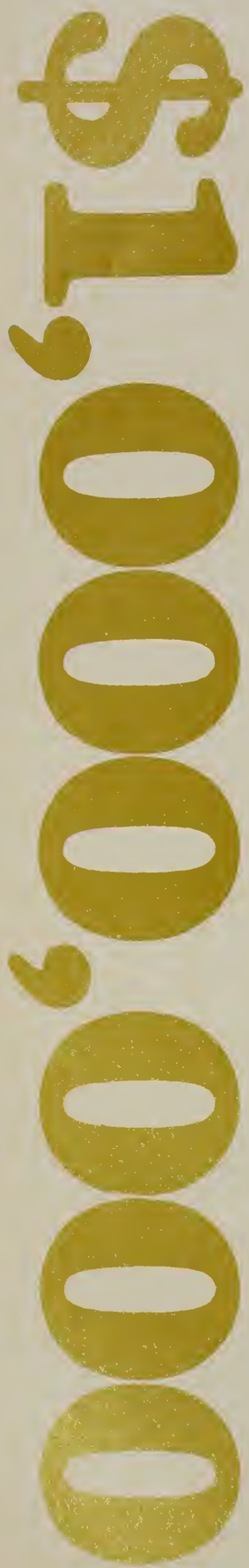
1 Million Question

By Tom Cashman

The rising tide of tension between hospital medical staffs and hospitals requiring physicians to carry a minimum of $1 million in professional liability coverage as a prerequisite for staff privileges crested in mid-November. The medical staff at Deaconess Hospital, Cleveland, moved to eliminate all but emergency admissions in protest of a policy many doctors find arbitrary and unfair to physicians in low-risk specialties and rural practices.

The requirement, imposed on hospitals by Ohio's largest hospital malpractice insurance carriers, threatens traditional cooperative relationships between hospital medical staffs and hospital administrators and trustees. It has also placed hospital boards at odds with their insurance providers.

Although many physicians already have at least this level of coverage, doctors are upset by the



mandated nature of the requirements. They also fear increased likelihood of becoming defendants in "deep pocket" malpractice actions if professional liability coverage levels are standardized and the amount of coverage is known by plaintiff attorneys.

The situation is even more muddled by admissions from hospital malpractice insurance carriers that the requirements may be arbitrary and a mechanism of administrative convenience. Doctors say the policy leaves some physicians overinsured, driving up the cost of medical care for many patients.

Concerns about the situation in Ohio began in 1984 when the St. Paul Insurance Companies and the Ohio Hospital Indemnity Corporation (OHIC), who together insure 75% of Ohio's hospitals, required their insureds to mandate the $1 million minimum as a prerequisite for medical staff privileges.

By June 1, 1985, both companies had their policies in place. The St. Paul made its program mandatory in all 45 states in which it provides hospital liability insurance coverage. Last spring, OHIC made its demand effective, but with a 10% surcharge on the premiums of hospitals not in full compliance. According to Duane Crone of OHIC, 50% of his company's insureds opted to pay the surcharge in 1985. Effective June 1, 1986, all OHIC renewals must comply with the requirements.

Policy Rationale

Mandatory coverage minimums are needed, the companies say, because of documented cases in which physicians have not carried enough insurance and hospital carriers have had to make up the difference — even in judgments in which the physician has been assigned the largest share of liability.

In a booklet mailed to its insureds in May 1984 announcing the policy, the St. Paul outlined its justification for the requirement saying "insured hospital and medical staff members have been absorbing substantial losses and costs for malpractice claims caused by hospital [medical] staff members who do not have adequate malpractice protection." The St. Paul estimates such losses represent between 10% and 15% of the total of "high value" hospital malpractice losses.

The company says its policy is based on the "deep pocket" theory of malpractice cases, in which to collect a large award, a plaintiff attorney will bring suit against not only a primary defendant but also against any colleague who even remotely participated in a patient's care.

If an incident occurs in a hospital, where the St. Paul says 75% of all doctor-related malpractice claims and the greatest percentage of high-cost claims originate, it is likely the hospital will be joined in the suit with the primary defendant physician. The company maintains these scenarios are especially probable when the primary physician is insufficiently covered.

Under Ohio's current tort system, a hospital may be held liable for a physician's share of a judgment. This is called joint and several liability — meaning even if both a physician and a hospital are held jointly liable in a malpractice action, either party could be forced to pay the full amount.

Although a hospital does have the right to sue a physician for the latter's portion of the amount owed the patient, it may be left paying the full amount if the physician doesn't have assets or adequate insurance to pay the judgment.

The St. Paul says if any co-defendant does not have sufficient

insurance coverage, other defendants will be required to assume additional payments and "the hospital actually becomes an excess insurer for the defaulting [medical] staff member or a guarantor of sufficient funds to satisfy award payments." The company cites a case in which a hospital was assigned 12% of a liability judgment and ended up paying 88% of the settlement because the physician was insufficiently insured.

What ends up occurring, the St. Paul says, is eventually the costs are borne by all hospitals and medical practitioners in the form of increased insurance rates, with the members of the medical community who have adequate coverage paying the way for those uninsured and underinsured.

Physician Opposition

Objections to the policy from physicians have focused on the apparent arbitrariness of selecting the minimum coverage level to be set at $1 million. Doctors say this forces low-risk and rural practitioners to pay for medical professional liability coverage far in excess of what the local malpractice climate would dictate.

Another physician objection concerns the altering of medical staff bylaws. Some hospitals are mandating that the $1 million requirement be placed within medical staff bylaws, as opposed to being adopted as policy by boards of trustees. This creates additional tension between the boards and medical staffs, raising the spectre of the governing boards dictating terms of medical staff bylaws, an area usually the province of the medical staff. In an attempt to reduce these tensions, many hospital governing boards have decided to adopt the requirement at the governing board level.

The minimum malpractice coverage requirement has proved to be a mixed blessing for hospital boards of trustees. On the one hand, the requirement lessens the possibility of increased dollar pay-outs by the hospital in cases where there has been a judgment against both the hospital and a physician. On the other hand, the requirement raises the issue of hospital self-governance, where a third party insurer is dictating to the hospital the terms of doing business. Although most hospital boards might not challenge the condition as being unreasonable, they are upset at being placed in the middle — between physician staff members and hospital insurers. Hospital boards of trustees are the entities which have to enforce the policy established by the insurers. In numerous instances this has placed them at odds with their medical staff members.

Although most hospital boards might not challenge the condition as unreasonable, they are upset at being in the middle.

The legality of the required insurance coverage has been consistently upheld by the courts based in part on an expanded theory of corporate responsibility. In several instances, a hospital has been held liable for the negligence of a physician staff member, even when no employer/employee relationship exists. Although the physician may be an independent contractor, courts in some circumstances have held the hospital jointly liable. *Hannola v. Lakewood,* 68 Ohio App. 2d 61 (Ohio, 1980).

Little Chance of Successful Challenge

No case challenging application of the minimum coverage policy has been litigated in Ohio courts. However, according to legal counsel for the OSMA, the likelihood that such a regulation would be held invalid is quite small based on decisions in other jurisdictions.

The legal validity of the regulation is based on the right of a hospital to make policy for its own governance as long as such policies do not conflict with federal or state law. Ohio has no law that sets or limits the ability of a hospital to make any regulation concerning malpractice coverage as a requirement for medical staff privileges.

One possible attack to the mandated coverage could come if it was found that the requirement infringed on a physician's right to practice medicine. For instance, if a situation occurred in which a physician met all other requirements for clinical and medical staff privileges, yet was unable to purchase liability coverage and therefore was denied privileges, the physician could argue that the requirement was an infringement of liberty interests.

The courts have held that hospital boards may only make regulations relating to medical staff membership that are reasonably related to the operation of the hospital. *Sosa v. Board of Managers of Val Verde Memorial Hospital,* 437 F 2d 173 (5th Cir. 1971).

Physicians trying to challenge the regulations by citing their "unreasonableness" have failed. The courts have said the requirements are a reasonable application of hospital rights and responsibilities, and, in one case, *Holmes v. Hoemako Hospital,* 573 P. 2d 477 (Ariz. 1977), the court went so far as to justify the hospital requirement for coverage regardless of the insurance coverage level mandated. The



decision said the regulations protect the hospital from being forced to pay the physician's "share" of a liability case should the physician and a hospital be jointly sued and the physician not have adequate insurance coverage.

OSMA attorneys believe these cases are an indication that such hospital regulations would be held valid by Ohio courts.

The New York Variation

Another approach to mandated coverage could be that taken in New York. Under a recently enacted statute, hospitals are required to pay the premiums for professional liability coverage in excess of $1 million for their medical staff members. The hospitals, in turn, are reimbursed from a state-administered fund to which all third party payers of health care are required to contribute on a pro-rata basis. However, it is significant to note that the physicians are responsible for paying their own premiums for the first million dollars worth of coverage. The hospital's responsibility does not begin until the physician has paid for the initial million dollar coverage and has agreed to be available to provide emergency care for patients of the hospital. Virtually all hospitals in New York now require medical staff members to carry a minimum of $1 million in professional liability insurance. This requirement was established individually by each hospital, not mandated by insurance companies.

An Admission of Convenience

It is interesting to note that even Ohio's largest hospital insurance carrier, OHIC, acknowledges some level of injustice in the requirement:

"By selecting $1,000,000 as the minimum-requirement, we are fully aware of some inequities this represents," OHIC has written, adding, "A good case could be made that $1,000,000 is inadequate in today's climate for some specialists such as an obstetrician, a thoracic surgeon or a neurosurgeon. And perhaps some physicians who rarely are involved with invasive procedures may feel $1,000,000 to be too high. *Our establishment of a $1,000,000 minimum to comply is an attempt to keep the program relatively simple, consistent, and as easy as possible for hospitals to administer"* (emphasis added).

Physicians say this admission points to a program even the carriers know to be unfair, arbitrary and devoid of considerations of the marketplace, fostering needless increases in health care costs in what is supposed to be a cost-conscious atmosphere.

Both the OSMA and the AMA have opposed the mandated nature of the requirements. Substitute Resolution 38-85, approved by the House of Delegates at the 1985 OSMA Annual Meeting, urges that levels of required coverage be left to hospital medical staffs in negotiation with each hospital.

If a hospital medical staff makes a determination of minimum coverage necessary for malpractice premiums, the AMA and the OSMA believe all members of the medical staff should comply, emphasizing that those members who decide to "go bare" leave their colleagues who are covered in considerable jeopardy.

Substitute Resolution 38-85 says:

RESOLVED, That the Ohio State Medical Association encourage all physicians to carry appropriate amounts of medical professional liability insurance coverage, and be it further

RESOLVED, That the Ohio State Medical Association believes that unilateral actions by hospital boards of trustees or their insurance carriers to compel physicians to carry arbitrarily chosen amounts of medical professional liability insurance as a condition for medical staff appointment are inappropriate,

and be it further

RESOLVED, That the Ohio State Medical Association supports the right of a hospital medical staff to establish bylaws regarding malpractice insurance coverage in cooperation with the hospital boards of trustees.

At the 1978 OSMA Annual Meeting, delegates passed resolution 44-78 rejecting mandatory coverage requirements. The delegates supported the concept of each hospital medical staff physician having adequate medical professional liability coverage and the right of "all medical staffs to conduct the practice of medicine in facilities according to the rules and regulations governing the staffs as set forth in the bylaws and regulations drawn up and approved by both the medical staff and the governing board of the facilities." The OSMA delegates opposed "any unilateral action of hospital board of trustees that alters or by-passes previously adopted regulations of medical staff bylaws."

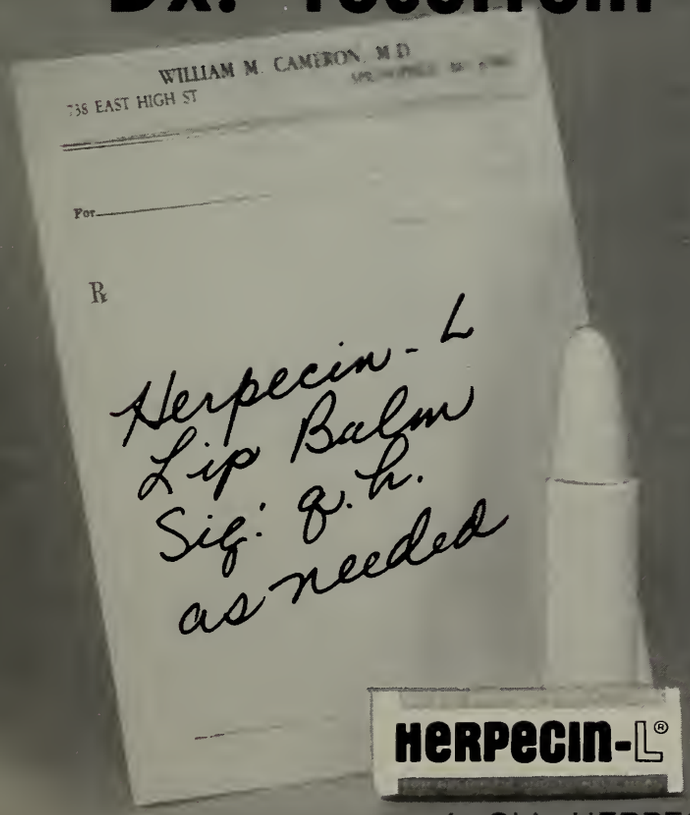
At the 1978 OSMA Annual Meeting, delegates rejected mandatory coverage requirements.

Deaconess Hospital and its medical staff have resolved the immediate problem of only admitting emergency patients for care. The hospital board has agreed to negotiate with a group representing the majority of the medical staff on all economic issues relating to the medical practices of the medical staff — including issues of malpractice coverage.

While the fundamental problem is still to be settled, a major first step has been achieved in establishing better communication between the medical staff and the hospital administration and board of trustees at Deaconess.

Tom Cashman is Associate Director of the OSMA's Department of Communications.

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29th ANNUAL OPHTHALMOLOGY SYMPOSIUM: March 3-4; Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus; sponsor: Department of Ophthalmology, Ohio State University College of Medicine; 15 credit hours; contact: Jon Hollett, Center for CME, Ohio State University, A352 Starling-Loving Hall, 320 West Tenth Avenue, Columbus 43210, phone: 614/422-4985.

CLINICAL ASPECTS OF ANOREXIA NERVOSA, BULIMIA & OBESITY: March 5-6: Bunts Auditorium, Cleveland Clinic; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours: fee: $170, $120 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

EVALUATION OF THE DIZZY PATIENT: March 7-8; Bunts Auditorium, Cleveland Clinic; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: $210, $160 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

INTERNATIONAL ENDOSCOPY SYMPOSIUM: March 13-15; Stouffer's Inn on the Square, Cleveland; sponsor: The Cleveland Clinic Educational Foundation; 18 credit hours; $350; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

MULTIPLE SCLEROSIS SEMINAR: March 13-14; Bunts Auditorium, Cleveland Clinic: sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: $170; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

NUTRITION CONFERENCE: March 17; Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus; sponsor: Ohio State University College of Medicine; contact: Jon Hollett, Center for CME, Ohio State University, A352 Starling-Loving Hall, 320 West Tenth Avenue, Columbus 43210, phone: 614/422-4985.

CURRENT HEALTH CARE ISSUES IN AIDS: March 19; Bunts Auditorium, Cleveland Clinic; sponsor: The Cleveland Clinic Educational Foundation; 6 credit hours; fee: $90; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone; Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

PULMONARY DISEASES — AN UPDATE — 1986: March 20; Holiday Inn, I-75 & St. Rt. 55, Troy; sponsor: Dettmer Hospital, Troy; jointsponsor: Wright State University School of Medicine; 6 credit hours; $60, #30 for students; contact: Gerard F. Wolf, M.D., 145 Sunset Drive, Piqua 45356, phone: 513/773-8323.

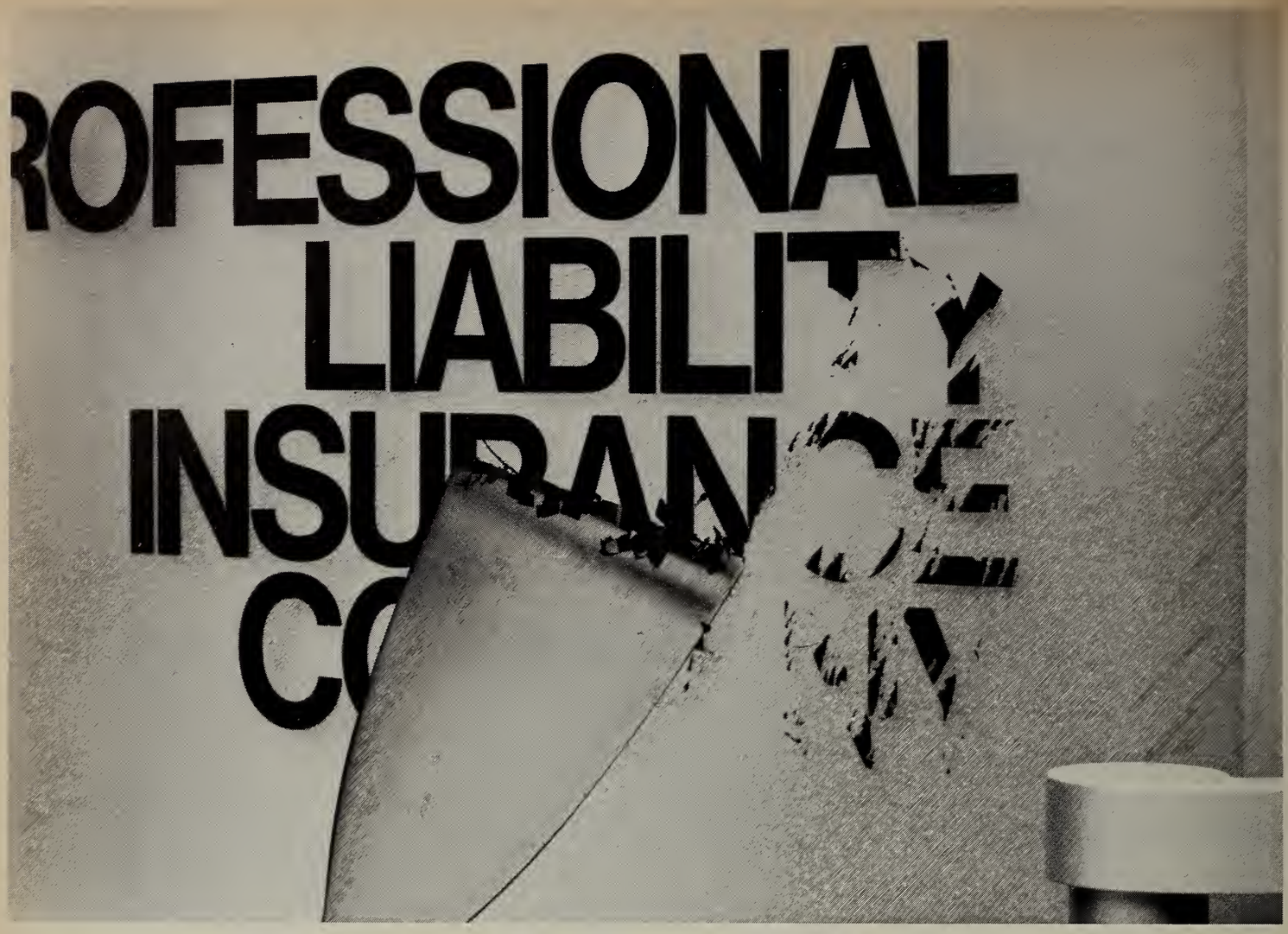
FLUIDS AND ELECTROLYTES: March 20; St. Elizabeth Hospital Medical Center, Youngstown; sponsor: St. Elizabeth Hospital Medical Center; jointsponsor: MSAHEN; 3 credit hours; no fee; contact: Rashid A. Abdu, M.D., St. Elizabeth Hospital Medical Center, 1044 Belmont Avenue, Youngstown 44501, phone: 216/747-7211.

ADVANCES IN UROLOGY: March 20-21; Bunts Auditorium, Cleveland Clinic; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: $220, $170 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone; Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

PULMONARY MEDICINE UPDATE: March 24-27; The Americana Dutch Resort Hotel, Lake Buena Vista, Florida; sponsor: Cleveland Clinic Educational Foundation; 16 credit hours; fee: $280; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

APRIL

8TH ANNUAL "CONTEMPORARY CONCEPTS IN OTOLARYNGOLOGY": April 20-27; Caneel Bay, St. John, U.S. Virgin Islands; sponsor: Communicative Disorders Foundation; co-sponsor: University of Cincinnati Medical Center; 30 credit hours; contact: Ms. Robbie Cornelison, Communicative Disorders Foundation, M.L. #528, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-4155.



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Obituaries

PAUL H. BEAVER, MD, Leetonia; Case Western Reserve University School of Medicine, 1922; age 88; died July 17, 1985; member OSMA and AMA.

JOHN W. BROGAN, MD, Cincinnati; Georgetown University School of Medicine, Washington, D.C., 1960; age 51; died October 14, 1985; member OSMA and AMA.

RICHARD D. BRYANT, Cape Elizabeth, Maine; University of Cincinnati College of Medicine, 1933; age 78; died July 11, 1985; member OSMA and AMA.

STANLEY L. BURKHARDT, MD, Sun City Center, Florida; University of Cincinnati College of Medicine, 1932; age 81; died October, 1985; member OSMA and AMA.

MELVIN M. CHRISTIAN, MD, Yadkinville, North Carolina; Howard University College of Medicine, Washington, D.C., 1933; age 82; died October 10, 1985; member OSMA and AMA.

GERALDINE CROCKER, MD, Madison, Wisconsin; University of Michigan Medical School, Ann Arbor, Michigan, 1924; age 88; died October, 1985; member OSMA and AMA.

EUGENE F. DAMSTRA, MD, Lebanon; Northwestern University Medical School, Chicago, Illinois, 1933; age 79; died November 9, 1985; member OSMA and AMA.

ALBERT H. DEGARMO, MD, Cincinnati; University of Cincinnati College of Medicine, 1951; age 59; died October 11, 1985; member OSMA and AMA.

C. THOMAS FULTZ, MD, Cincinnati; University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania, 1951; age 59; died October 21, 1985; member OSMA and AMA.

CLIFFORD G. GRULEE, MD, Cincinnati; Emory University School of Medicine, Atlanta, Georgia; 1971; age 40; died October 1, 1985; member OSMA and AMA.

WALTER MENDYKE, MD, Westlake; University of Cincinnati College of Medicine, 1951; age 62; died October 15, 1985; member OSMA and AMA.

BARNEY OSBORNE, JR., MD, Ironton; University of Cincinnati College of Medicine, 1953; age 61; died September 17, 1985; member OSMA and AMA.

HARRY H. ROBINSON, MD, North Little Rock, Arkansas; University of Arkansas School of Medicine, Little Rock, Arkansas, 1927; died October 2, 1985; member OSMA and AMA.

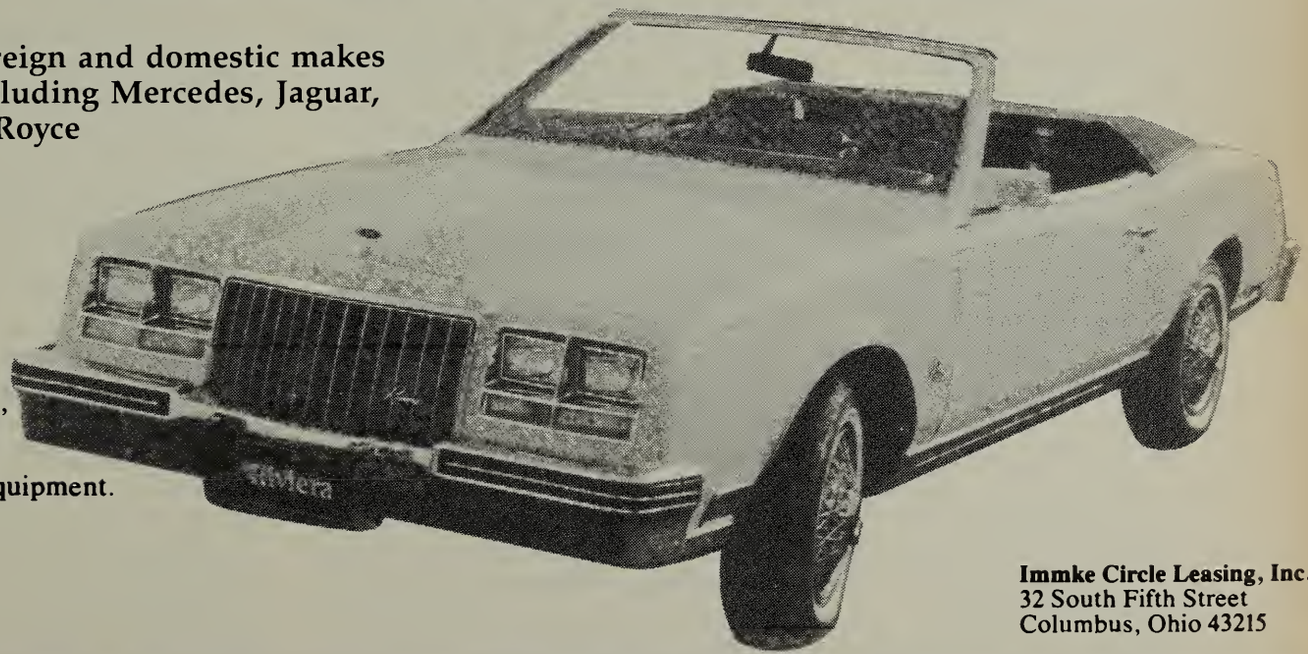
JOSEPH SCHLERNITZAUER, MD, Yorkville; St. Louis University School of Medicine, St. Louis, Missouri, 1918; age 91; died November 1, 1985; member OSMA and AMA.

ROBERT L. TAYLOR, MD, Lebanon; Yale University School of Medicine, New Haven, Connecticut, 1943; age 68; died November 13, 1985; member OSMA and AMA.

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First District

Stanley Lucas, MD

High quality care and the one-to-one relationship between physician and patient — these are the primary reasons why Stanley Lucas, MD, a Cincinnati radiologist, is in the private practice of medicine. They are also why he currently is serving as the First District Councilor of the Ohio State Medical Association. "This is what I found in medicine when I came into it," he says. "And that's what I'd like to leave behind for the next generation."

Despite the pressures currently existing in the climate of medicine which threaten to lower the quality of care and to disrupt the traditional doctor-patient relationship, Dr. Lucas is adamant that both must be preserved — and that this can best be done through the efforts of organized medicine. This is not an easy task, however, due chiefly to the increased demands currently being placed on today's physician.

"I sometimes find myself having to fit a practice in between the phone calls," he says, speaking not only of his involvement with the OSMA, but also of his past and present activities with the Cincinnati Academy of Medicine and of his work as an alternate delegate to the American Medical Association.

Being highly involved in organized medicine, he says, takes time away not only from a practice, but also from other professional and personal activities. But the joys of being involved outweigh the frustrations, he believes. "And the greatest joy is knowing that you're working for organizations that are trying to protect what is best in medicine," he says.

Dr. Lucas had his first contact with organized medicine as a medical student at the University of Cincinnati, where he earned his MD degree in 1951. "The (Cincinnati) Academy meetings were held at the medical school," he recalls, "and the Academy brought in all of the outstanding speakers. The Academy continued to be a prime source of professional information for me," he says. Later, he was asked to become more involved in the local medical society, serving first on various committees, and then as secretary and councilor-at-large before assuming the presidency of the Academy in 1976.

Dr. Lucas became an alternate delegate to the OSMA in 1975 and a delegate in 1976. He was elected First District Councilor last May. In addition, he has served as an alternate delegate to the AMA since 1982.

Involvement at all levels of organized medicine is not the only activity that robs him of time from his practice, however. "I think the biggest problem for all physicians today is the pressure

from all of the rules and regulations placed on us by the insurance companies, government agencies and other regulatory bodies — and all of the paper work this engenders," he says. The physician's primary responsibility is to provide the best care possible for the patient, he says. "Yet it can be very frustrating when you first have to determine if this care requires preadmission certification. Then you have to figure out what types of insurance the patient has. And then you have to follow all of the rules and regulations attached to the (insurance) programs." All of this adds up to a lot of investigation and paper work, he says, which ultimately takes away from the time a physician can spend with a patient.

The entry of competition and alternative health care delivery systems into the marketplace is also consuming a greater and greater portion of the doctor's time, he continues, forcing physicians to come up with new ways to "market" their practices to the public-at-large. But Dr. Lucas is more concerned about the animosity this competition creates — not only between physician and physician, but also between physician and hospital, hospital and hospital, insurance company and hospital, etc.

And there is still no proof that the increased competition lowers health care costs, he adds. In fact, it may even increase them. First there is the cost of the marketing and advertising programs — costs which must ultimately be absorbed by the system. In addition, "Everyone wants their share of the market," says Dr. Lucas. "So in fact what happens is that we increase the size of the market unnecessarily."

Still, physicians cannot afford to ignore or turn their backs on the new competitive forces currently underway. Dr. Lucas was among leaders of the Cincinnati Academy who spearheaded the formation of a non-profit IPA model HMO called Choice Care, so that physicians could continue their private practices, yet still maintain a competitive edge in the marketplace. While considerable controversy surrounded the conversion of Choice Care into a for-profit company last year, "I think physicians here are beginning to understand the importance of the IPA," Dr. Lucas says.

District One includes eight Ohio counties — all actively represented in the first delegation. However, Cincinnati — the largest of the cities in the district — has long been the hub of activity in District One and a statewide leader in addressing the needs of organized medicine. Physicians in that city are currently involved in a number of projects with that aim in mind.

One is a move to get more women physicians in the area involved in organized medicine. "One-third of our medical students are now women," Dr. Lucas points out. "So we are making a concerted effort in Cincinnati to make sure they are better represented. We want to see more women appointed to committees, serving on the (Academy) council and developing programs and guidelines that will help to meet their needs."

The Cincinnati Academy is also in the process of developing an ad hoc committee on medical ethics — another rapidly changing area in medicine today. "Ethics used to concern itself with *how* do you practice medicine," Dr. Lucas says. "Now it also involves *how much* care do you provide. Who should receive the vast array of high-tech medical care now

"The biggest problem for physicians today is the pressure from all of the rules and regulations placed on us."

Councilor Commentary

continued

available? What are the limitations? How long do we keep the person who is suffering from a serious illness alive on artificial support systems? How much care can we afford to provide? These are subtle issues, but medicine is going to have to face them soon. And we have to face them together with others in the community — with clergy, with social service workers, with lay leaders, etc.''

Cooperation between the various community members and service organizations involved in the care of the elderly is also the goal of a new Joint Council on Geriatric Care currently being spearheaded by the Cincinnati Academy of Medicine. The Academy has also sponsored two mini-internship programs, allowing lay members of the community to spend time on the job with physicians in a health care setting. This allows journalists, government and business leaders an opportunity to better understand the problems and needs the physician faces.

In another spirit of cooperation, the Cincinnati Academy joined forces with the Cincinnati Bar Association to develop a new Standards of Practice manual, spelling out guidelines and the adjudication process for handling complaints between physicians and lawyers. Dr. Lucas, who was heavily involved in that revamping, explains, ''Before this, there were a lot of smoldering complaints that doctors and lawyers were not cooperating. For example, in bodily injury cases, the lawyers were complaining that the doctors weren't getting their reports in on time. The doctors, on the other hand, complained that the lawyers were making and breaking too many appointments.''

''Today, doctors are being pressured and pulled in so many directions, that you're lucky to be able to represent 40% on any given issue.''

But the members of District One's largest academy are not the only ones who have been involved in projects aimed to improve health care in Ohio. Small counties in that district have also had an impact, says Dr. Lucas.

For instance, ''A resolution was introduced in Warren County last year promoting the mandatory use of seat belts,'' he explains. ''That resolution was then sponsored by the First District and passed the OSMA House of Delegates last May. But it all started in Warren County.''

Physicians in District One face many of the same kinds of problems as doctors throughout the state and country — too much paper work, too many time restraints, increasingly complex ethical issues, the rise in competition in the delivery of health care, and so on. But increasingly, their views and approaches to these problems are becoming more diverse, making it harder to represent all of the doctors all of the time, according to Dr. Lucas. For example, physicians in the larger cities worry about too much competition; those in the rural areas often work long hours without support. Some physicians are involved in alternative delivery systems; others are threatened by them.

It is this type of diversity within the membership that Dr. Lucas finds most frustrating as he tries to find a unified voice to represent his district on the OSMA Council.

''Up until two or three years ago, it was easy to represent at least 90% of the doctors on any one issue,'' he says. ''You always had a pretty good idea about how the majority felt. But today, doctors are being pressured and pulled in so many directions, that you're lucky to be able to represent 40% on any given issue.''

Yet this is the challenge he finds most rewarding and interesting as he strives to work towards the betterment of medicine and health care in this country. ''It is also rewarding to meet so many bright and articulate people who have this same goal in mind,'' he says.

— *Susan Porter*

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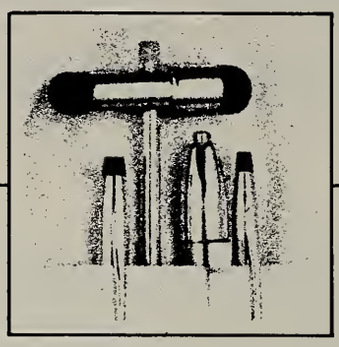
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Eleventh District

D. Ross Irons, MD

In 1982, when Eleventh District Councilor S. Baird Pfahl, Jr., MD, stepped into the office of OSMA President-Elect, D. Ross Irons, MD, was asked to fill the newly created vacancy. He admits he took some time to "think it over" — two or three weeks, to be precise.

It wasn't that Dr. Irons was shy of credentials for the job. A 1960 graduate of Ohio State University's College of Medicine, he had been a delegate and alternate delegate of the OSMA, and had served a term as President of the Huron County Medical Society. But the position of OSMA Councilor meant not only more time away from his busy general surgery practice in Bellevue, but an even higher level of commitment to organized medicine.

"I said yes because I felt the problems facing medicine were real, and that a straightforward attempt to solve these problems was indicated."

Fortunately, he adds, the majority of his district agreed with him — and with his characteristic straightforward, no-nonsense approach.

"I've been identified as a 'bottom-liner,' " Dr. Irons admits. "I'm not really a malcontent, but I'm not about to assume a passive role, either," he says.

In fact, the last couple of years have shown that the physician population seems to be catching up with his non-passive attitude, he notes.

"Physicians no longer exist in a state of agitated apathy. Most of them have come to the realization that they must become involved in medicine's issues — even though the position they take may not always be the most popular."

But if medicine's positions *seem* unpopular, it is only because more education is needed, he says. Everyone from third-party payors to corporations and the public-at-large need to be educated on how to retain quality patient care.

"That's where I'm coming from — that's the bottom line," he says.

Certainly, public education is a



D. Ross Irons, MD

project he is promoting in his own district, which covers a rapidly developing section of the state, stretching from Lake Erie downwards to include Ashland, Erie, Holmes, Huron, Lorain, Medina, Richland and Wayne Counties.

"You can no longer characterize this area as rural," declares Dr. Irons, pointing out that the Sandusky-Lorain area and the Akron-Medina area are heavily industrialized now, assuming all of the "big-city" problems that go along with their more complex, urban profiles.

One of these problems, says Dr. Irons, is the rapid influx of the alternative health care systems, which are naturally increasing competition in the area. Just how *long* this competition will continue, however, isn't clear — at least not in Dr. Irons's mind.

For example, he thinks that PPOs, as they exist in their current form, will die in five to seven years, and that HMOs will become limited.

"Think about it," he urges. "Once you have a PPO in your area, why would you have another? And it's been shown that the capitated plans of most HMOs are not the most cost-effective way to deliver care."

In fact, he continues, different capitation rates are generally required for different age groups in *all* forms of alternative health care systems — including the financially successful IPAs, and that's what leads to his primary concern with these systems.

"I support competition," he says, "but I'm concerned about the health care rationing that's evolving from these alternative forms. We already have it, to a certain extent with Medicare and Medicaid, and, in a short time, it is bound to turn up in the private sector."

He's predicting that the straight-capitation HMOs will have to either be re-negotiated, or exist in some other form if they are to survive, but Dr. Irons has serious doubts as to whether or not any of the alternative forms *should* survive.

Third-party payors are taking advantage of the public's concern over rising health care costs and are promoting alternative care systems — "to the detriment of patient care."

"I think they are an over-reaction to a *perceived* problem," he says. "Physicians have kept down costs sufficiently."

But, according to Dr. Irons, third-party payors are taking advantage of the public's concern over rising health care costs and are promoting the alternative care systems — "to the detriment of patient care," he adds.

Besides their "less than optimal" system of delivering care, Dr. Irons adds that alternative systems are creating other problems.

"They are pitting physician against physician, and hospital against hospital," he says. "The members in my district are sitting back to see what's going to happen, but they are already perceiving that these forms are not a panacea."

Of course, the number-one problem in his district — and all over — is the medical liability problem.

As a member of the Governor's 1984 Commission to study Health Care Costs, Dr. Irons became well-grounded on the subject of professional liability. Naturally, this year, when the OSMA formed its task force on professional liability, Dr. Irons was included as one of its members and asked to be chairman of its subcommittee on Public Education and Coalitions.

"One of the things we're attempting to do is obtain a much needed change in tort reform," he says, noting that such changes have already been accomplished in Michigan, Florida, Illinois and New York, as well as several other states.

And, here again, he turns to public education as a means of accomplishing his goal.

"I think if the public were properly informed and educated on the problems of professional liability — they would accept tort reform," he says.

But Dr. Irons is not expecting this acceptance to occur overnight. "The political and judicial climate is such that we can't expect immediate acceptance." In time, however, Dr. Irons feels sure that changes *will* take place.

He hopes so, anyway.

With the recent requirement made by the St. Paul Insurance Company requiring doctors to

carry $1 million professional liability (see related story elsewhere in this issue), some type of change will have to be made soon.

But he believes physicians will have to effect these changes individually. "If we try to make a collective decision on what needs to be done, we come out looking self-serving."

Even individual decision-makers need to work together, however, and he sees the OSMA and organized medicine playing a vital role in organizing and coordinating these efforts.

"Although the degree of physician interest is improving, the physicians of Ohio are largely uninformed on what the OSMA has done and is doing for medicine," he claims.

That's one reason he applauds the organization's recent public education campaign, for it has not only brought matters to public attention, but to physician attention as well.

"Most of the counties in my district have gone ahead with the campaign, and we've found that it has made the physicians here open up and talk about the issues. More of this needs to be done." He also applauds the activities of the OSMA Auxiliary, pointing out that its legislative efforts, as well as its programs to educate and inform the public on these issues in various parts of the state have been enormously effective.

But he would like to see *every* physician as informed as the OSMA councilors and delegates.

"If they were, we probably wouldn't have any problems," he notes.

As it is, the problems for medicine are still out there — and he believes that organized medicine and the OSMA will have to be more aggressive and innovative in the next few years, if it hopes to meet these problems head-on.

"The for-profit companies, the third-party payors, the corporations will all have more clout in the years to come. We need to have a plan in place that will bring physicians together — as negotiators or arbitrators or whatever — to meet these challenges and to assure that quality patient care will continue to be delivered in the future."

— *Karen S. Edwards*



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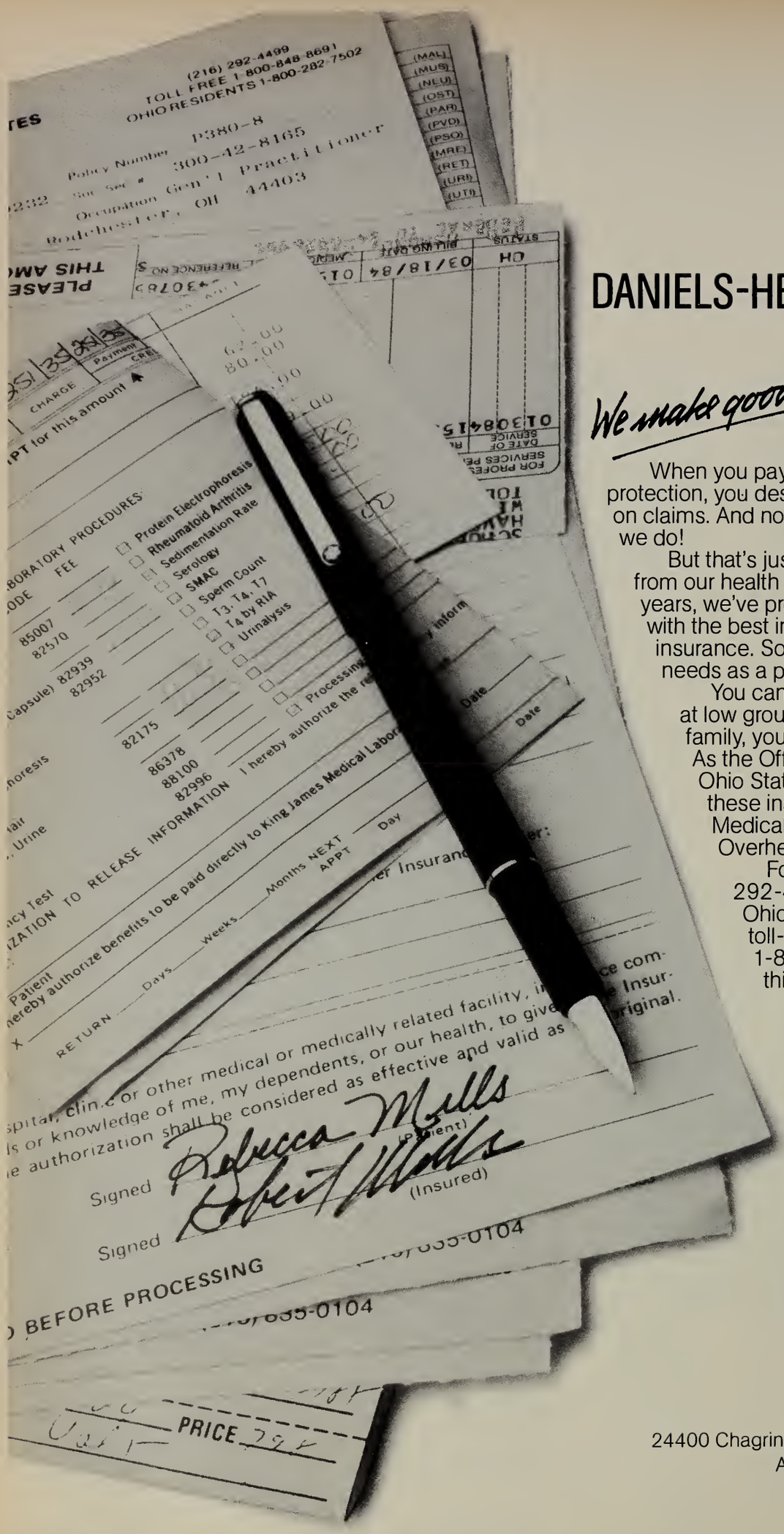
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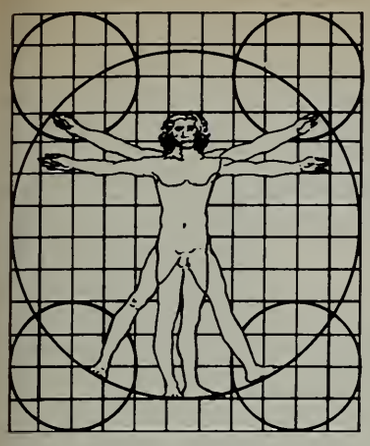
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CLINICAL & SCIENTIFIC

A CLINICAL APPROACH TO THE DIFFERENTIAL DIAGNOSIS OF THE DEMENTIA PATIENT

Edwin C. Shuttleworth, MD

Sixty-three out of eighty-two patients with dementia were separated by final diagnosis into two groups; those with dementia of Alzheimer type (untreatable) and those with vascular dementia, or "pseudo dementia," associated with psychiatric disease (treatable). Seven features of a standard neurobehavioral examination were found to be particularly valuable in the early clinical differentiation of these two patient groups, thus offering a more efficient and less costly approach to the dementia patient.

INTRODUCTION

The dementia syndrome is estimated to affect perhaps 10 to 15 percent of persons over the age of 65 and, therefore, will be encountered frequently by most practicing physicians seeing adult patients. As presently constituted, the examination and work-up of such a patient is quite extensive and costly since the primary goal must be to exclude treatable disorders. Recent progress in the field of neuropsychology, however, has led to considerable interest in attempting to make a positive diagnosis, especially with respect to dementia of Alzheimer type (DAT), which probably accounts for nearly 50% of demented individuals.[1-3] On the possibility that this sort of approach might offer a more efficient examination schema for the practicing physician, results of a detailed neuropsychological investigation were analyzed for 85 patients seen over the past several years for complaints or findings suggestive of a dementing illness. Though the diagnosis was readily suggested by the neurological examination in some patients, most commonly little abnormality was found outside of the "mental status," and the major problem became one of distinguishing DAT from vascular dementia or from dementia apparently based upon a psychiatric disorder — a particularly important distinction from a therapeutic point of view. Several key features of the neurobehavioral examination of patients falling into these categories were found to be useful in early differential diagnosis.

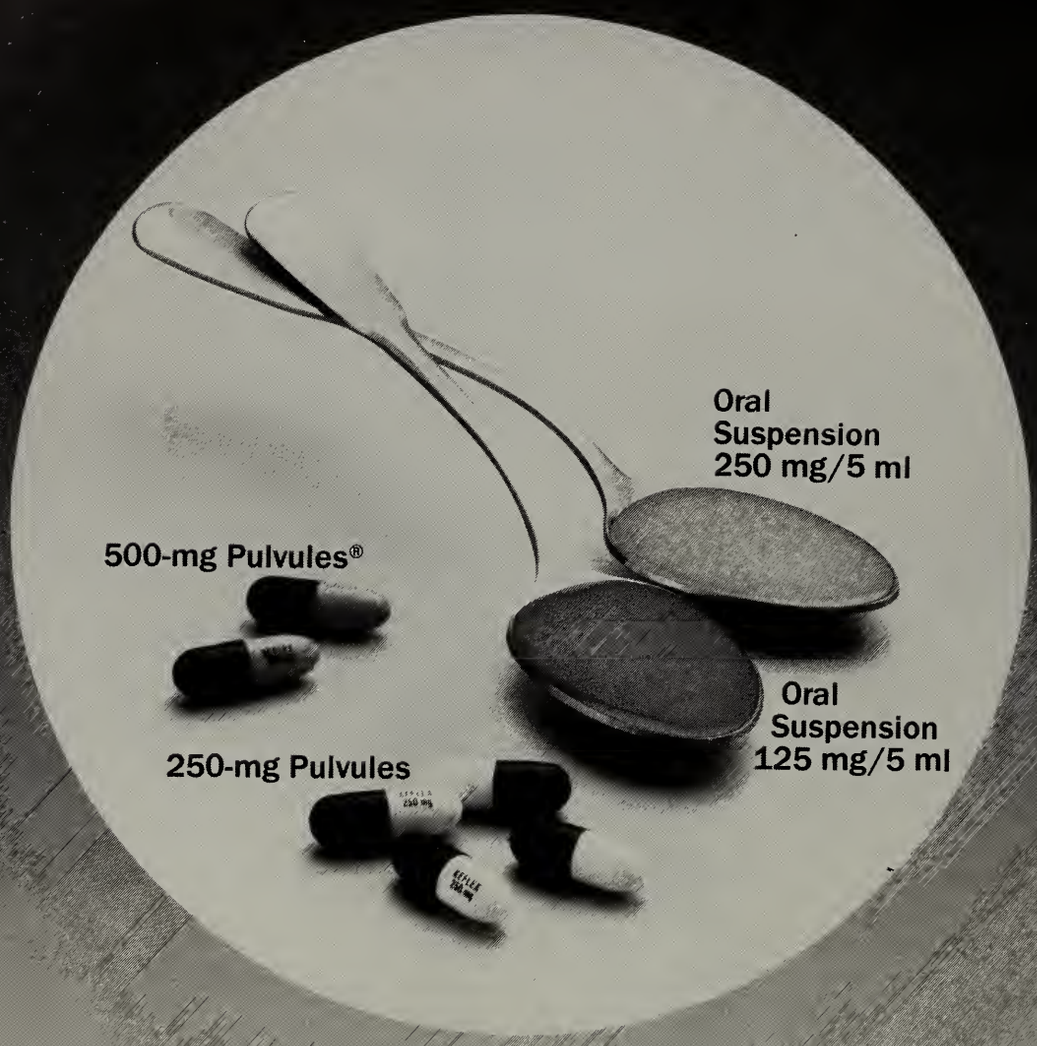
The purpose of this report is to suggest that diagnostic accuracy can be enhanced and the physician's time can be saved by the adoption of a relatively small number of tests suitable for the clinical evaluation of the patient with a history of an acquired deterioration of the intellect, whose diagnosis has not been obvious on the basis of the standard examination.

METHODS

Eighty-two patients referred to the Ohio State University Hospitals for symptoms or findings suggestive of a dementing illness were evaluated by use of the standard history, neurological examination, special neurobehavioral evaluation,[4,5] and suitable work-up. Nine patients with a diagnosis of mixed dementia (DAT plus vascular dementia) were excluded from this study, as their clinical features formed a composite of those found typical of DAT and vascular dementia. Several other patients with diagnoses such as Creutzfeldt-Jakob Disease, Parkinsonism, and progressive supranuclear palsy, were also excluded because their diagnoses were readily suggested by standard examination procedures. The remaining 63 patients form the basis of this report. Forty-five of these patients eventually received a diagnosis of DAT based upon current criteria for that disorder.[6,7] Eight patients received the diagnosis of vascular dementia based upon the presence of focal findings on neurological examination with modified Hachinski ischemic scores of 4 or greater,[8] often accompanied by lesions interpreted as areas of infarction on CT scan. A psychiatric disorder with "pseudodementia" was diagnosed in 10 patients on the basis of a clinical impression of the presence of significant psychiatric disease, usually an affective disorder, in the absence of structural involvement of the central nervous system. These 63 patients were grouped into two categories on the basis of their final diagnoses for a comparison of DAT patients with those having either vascular dementia or pseudodementia (presently untreatable vs. common treatable dementia syndromes), giving a total of 45 and 18 patients in these two groups respectively. Their neurobehavioral features were tabulated, and on inspection, nine fea-

Edwin C. Shuttleworth, MD, is an associate professor in the Department of Neurology at The Ohio State University College of Medicine in Columbus, Ohio.

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tures seemed to offer some potential in distinguishing the two groups. These features included orientation, abstracting ability, verbal memory, visual memory, verbal fluency, picture anomalies test, construction, geographic orientation, and calculating ability. These features were then subjected to statistical analysis by logistic regression, and probabilities that the two groups differed from each other with respect to each feature were calculated by the use of Fisher's exact probability test. Data was not available for every patient in each category of the examination. Twenty-two approximate age and education-matched subjects judged to be free of central nervous system disease served as controls.

The neurobehavioral examination was used as previously described[5] with the following alterations or clarifications: orientation was evaluated after the method of Folstein and co-workers,[9] and was considered to be normal if all aspects were correct with the exception of an error of plus or minus 2 days in the reporting of the date. Verbal recent memory was assessed by the oral presentation of several phonemically and semantically dissimilar words to the patient, having him repeat the given words immediately and then again after a delay of two to five minutes during which verbal distraction was carried out. Performance was considered to be within normal limits if two out of three words were correctly recalled after that time interval, recognizing that this was a rather generous estimate of acceptable performance.[10,11] Controls in this study achieved a mean performance of 2.68 words correct out of three. Visual recent memory was tested by the presentation of a series of five abstract designs drawn in India ink on individual cards. A similar series of readily nameable objects were also presented as India ink drawings and, immediately after presentation of each set, the patient was required to point to the correct design out of four possibilities for each figure in succession. Control patients achieved a score of 9.4 items correct out of 10, and a score of 8 correct out of 10 was accepted as being within normal limits for purposes of this study. The picture anomalies test was administered and scored as described by Wells and Ruesch[12] who considered 8 correct out of 10 to be normal, though controls in this study were correct on 9.8 out of 10. Abstracting ability was tested by asking the patient to explain the similarity between two different items using a set of three or four pairs of items of increasing difficulty as described by Strub and Black.[10] Verbal fluency was assessed by asking the patient to name as many words in the English language as he could, excepting proper names, within one minute. Categories used were the letters S and P and animals.[13] Controls produced 14.5 and 14.4 words per minute beginning with the letters S and P respectively, and 19.0 animals. An average score of less than 10 was considered abnormal in any category for the purposes of this study. Constructional ability was tested by having the patient copy standard figures including a horizontal diamond, interlocking pentagons, a transparent cube, and a pipe. Scoring was accomplished as described by Strub and Black.[10] Geographic orientation was tested by asking the patients to indicate the location of each of five large cities on an outline map of the state of Ohio. A deviation score was calculated as the error in inches per city on the map which had a scale of 50 miles to the inch. Controls had a mean error score of .52 inches per city, and an error score exceeding this mean by two standard deviations was considered abnormal for the purposes of this study. An assessment of geographic orientation for patients who are not familiar with the state of Ohio can be made by utilizing a map of the United States as described by Benton and co-workers.[14]

RESULTS

Geographic disorientation was found to be 100% specific in identifying patients as having DAT, but was only 61% sensitive. Abnormal abstracting ability, though not very specific (53%), was 100% sensitive; i.e., all patients ultimately found to have DAT had abnormal abstracting ability. Abnormal performance on the picture anomalies test on the other hand, was both a specific (91%) and sensitive (92%) indicator of the presence of DAT and seemed, therefore, to be the best single test for differentiation of the two groups. What the picture anomalies test actually measures is uncertain,[15] but it may bear some relationship to judgment.[12] Constructional ability, orientation, verbal memory, and verbal fluency were all found to be quite sensitive indicators of DAT (approximately 90%), but were not very specific to that diagnosis (53 to 67 percent specific), suggesting that patients eventually found to have DAT are in general more severely and globally demented than are patients with other types of dementia when first seen by the physician. This is in agreement with the experience of others.[16] Visual memory and calculating ability were neither very specific (approximately 70%) nor very sensitive (64% and 77% respectively) indicators of the presence of DAT, but in the case of visual memory, some utility was derived from its use as a marker of nondominant temporal lobe dysfunction. Probabilities that the two patient groups differed from one another in performance on each of the nine selected tests (Fisher's exact probability) were all significant, varying from $P = .025$ for verbal fluency to $P < .000005$ for constructional ability, picture anomalies test, and abstracting ability.

DISCUSSION

Estimates of the incidence of DAT vary from 22% to 57% of patients presenting with the dementia syndrome.[3] With the best research criteria, probably about 85% of patients with DAT actually have Alzheimer's Disease at autopsy. This is presently not as great a problem, however, as is the potential for missing the diagnosis of a treatable dementing disease; and physicians have been encouraged repeatedly to be thorough in ruling out such disorders, irrespective of the cost of such an undertaking. While this is certainly an admirable goal, it would seem appropriate, encouraged by Benson,[17] at least to attempt to screen patients for a positive diagnosis of DAT, thereby reducing the work-up to some extent, and, as a result, the overall cost of medical care.

The present study reveals that a relatively manageable number of items from the neurobehavioral examination appears to have a high incidence of abnormality in patients seen predominantly in an office practice, who ultimately were diagnosed as having DAT. These items include abstracting ability, the picture anomalies test, orientation, verbal memory, verbal fluency, constructional ability, and geographic orientation. The fact that geographic orientation was found to be 100% specific, while abstracting ability was 100% sensitive for DAT, suggests that the use of these two tests together would afford the most parsimonious means of discrimination of the two groups. The picture anomalies test, which was both sensitive and specific, would provide further assurance of success in discrimination, while the addition of the other four tests would aid in covering other important aspects of the dementia syndrome (i.e., memory, language, and visuospatial function). Each of these items appears to have reasonable specificity, is easily administered and relatively easily interpreted, and requires little in the way of equipment or specialized experience. Together they should significantly increase the incidence of a correct diagnosis when added to a history which probes the character of onset of the disease and its progression in an alert patient who meets the definition of a dementia syndrome, and a neurological examination which searches for focal neurological deficit, ischemic features, or affective disorder.

Clearly the employment of the above schema does not replace thoughtful clinical judgment, careful follow up, and the judicious use of ancillary diagnostic procedures; but, nonetheless, it can result in both a significant reduction in the cost and an increase in accuracy of diagnosis of the dementia patient.

SUMMARY

The effectiveness of a detailed neurobehavioral examination in the differential diagnosis of the dementia patient was evaluated. Forty-five patients who eventually met current criteria for

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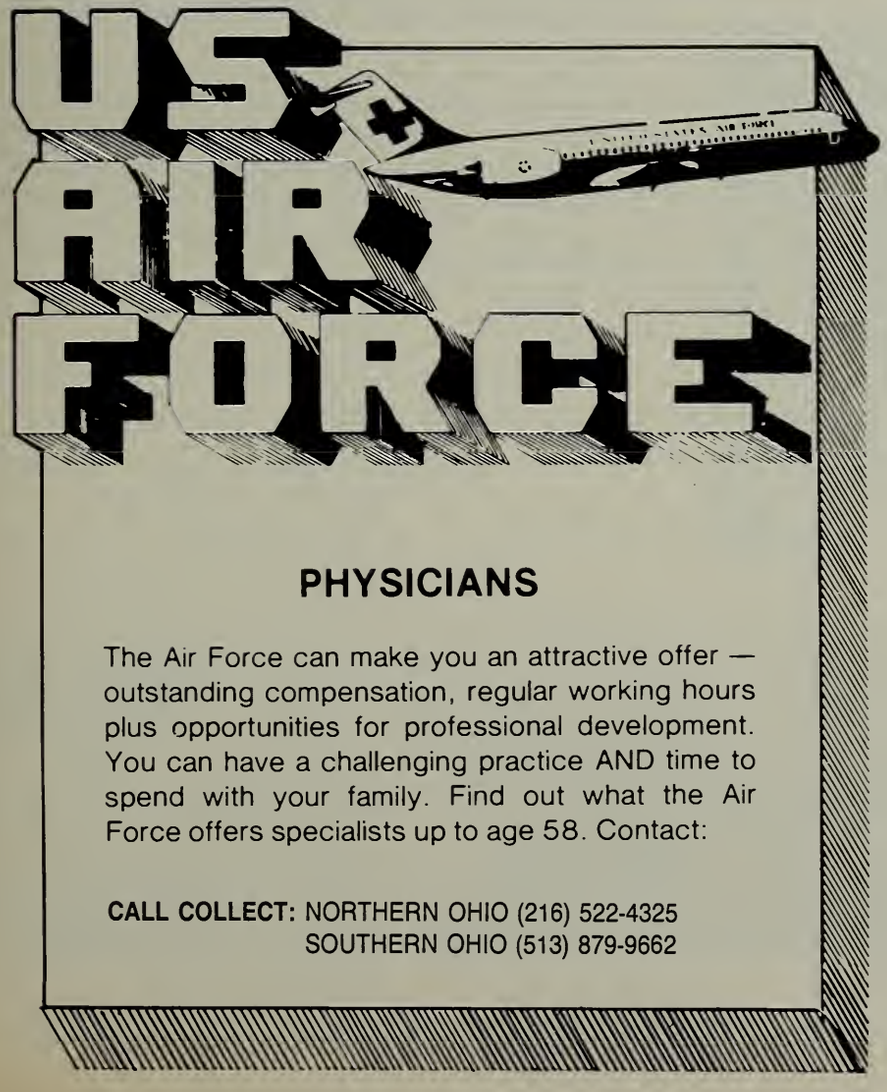
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dementia of Alzheimer type were compared with 18 patients found to have either of two common treatable dementias (vascular dementia or pseudodementia associated with psychiatric disease). Seven specific features of the neurobehavioral examination proved to be most helpful in differentiating these groups at a stage in their disease when they would most likely be seen in a predominantly outpatient practice. It is suggested that clinical evaluation can be made more efficient by the incorporation of these tests into the neurological examination of the patient with dementia.

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Racial health gap disclosed

A task force has been at work this past year to determine why the mortality rate among blacks remains almost 50% higher than among whites, according to Health and Human Services Secretary Margaret M. Heckler.

Plans to close this gap will begin later this year after the task force presents its findings. Heckler suggests the death rate among blacks can be greatly reduced with "a few fundamental changes in lifestyle."

The task force has pinpointed six major causes of death that seem to be more prevalent in blacks. These areas have not yet been revealed, but previous studies indicate that homicides, heart attacks, strokes, cancer of the digestive tract, and accidents contribute greatly to the higher death rate in blacks.

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Osa Reimann
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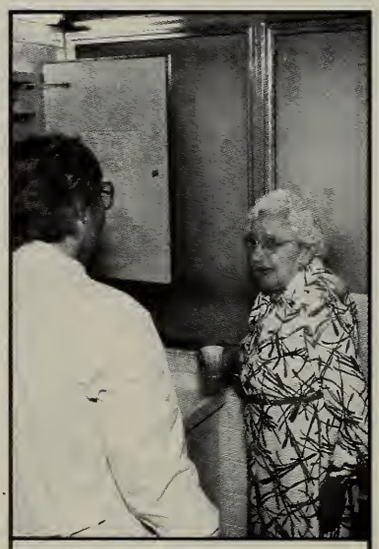
"Now I'm happy," says Aunt Osa. "I can walk much better. I eat well. I don't have to cook or do dishes. I have my own things. Many times when my niece calls me I'm down the hall visiting friends or taking part in an activity. I go to exercise class every day. I do as much as I possibly can."

"Aunt Osa has her own room at our house, too," says Frank. "She stays with us every Sunday and Monday. We have fun together whether we stay home or go out. And, when we take a trip, we don't worry about Aunt Osa. You know, the Danes make the most of each day. And that's what living at Judson is all about."

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Emergency Physicians Needed For Full-time Emergency Positions in modern community hospital in southwest Ohio. Moderate volume, competitive salary, malpractice insurance and flexible schedule. Positions available immediately and in July. Contact William R. Grannen, Medical Health Services, Inc., 7329 Ticonderoga Ct., Cincinnati, OH 45230, (513) 231-0922.

FAMILY PRACTITIONER/BC/BE to join medical clinic in northeastern Ohio community. Attractive salary, fringe benefits. Send C.V. to: Niles Medical Clinic, 423 Robbins Avenue, Niles, OH 44446 (216) 399-7850.

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Board eligible/certified family practitioners to associate with board certified general surgeon. Guarantee: competitive salary, benefits, coverage, full privileges. 24 hour emergency room coverage. Contact: Village Medical Clinic, 1814 Enslee Road, Coshocton, OH 43812. Phone: 614-622-7497 after 7:00 p.m.

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GENERAL SURGERY PRACTICE — NORTHERN OHIO. Established 16 years, grossing over $300,000. Avg net last three years — $189,000; 5000 active charts. Pop. 60,000. GM investing 6 million in trade area. Reply to Box No. 81, c/o Ohio State Medical Journal, 600 S. High St., Columbus, OH 43215.

FOSTORIA, OHIO — Directorship and full time emergency department position available at moderate volume facility within one hour drive of Toledo. Attractive compensation with malpractice insurance provided. Please submit resume to Emergency Consultants, Inc., 2240 South Airport Road, Room 26, Traverse City, MI 49684; or call 1-800-253-1795 or in Michigan 1-800-632-3496.

HOLISTIC DOCTOR. Compensation $25-$30 per hour plus percentage. Solo practice. All equipment, personnel furnished. No start-up fees. Excellent growth potential. Send CV and recent photo to: MLG Health Care Corporation, 1100 Wilmington Ave., Dayton, OH 45420.

INTERNAL MEDICINE/OB-GYN
Hospital-based and housestaff physicians needed for excellent suburban hospitals. Cleveland, OH area; high income; must have Ohio license. Immediate openings also in ER, Urgent Care. Send CV to Physician Staffing, Inc., 29525 Chagrin Blvd., Cleveland, OH 44122 or call (216) 292-7445.

Classified advertising

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MARIETTA, OHIO — Emergency Department directorship and staff position available at 200-bed facility. Board certification or board eligibility in Emergency Medicine or primary specialty preferred. Contact: Emergency Consultants, Inc., 2240 S. Airport Road, Room 26, Traverse City, MI 49684; or call 1-800-253-1795, in Michigan 1-800-632-3496.

OCCUPATIONAL MEDICINE TRAINING

Mini-residency beginning June 9-20, 1986 and continuing October 20-24, 1986 and March 16-20, 1987. Clinical and administrative occupational medicine, epidemiology and biostatistics, industrial hygiene, toxicology, regulations, etc. 111 AMA Cat I, AAFP prescribed, Cat 2-D AOA and Cat I ACEP credits. 10th year. References from past participants provided. $650 per week. Sidney Lerner, MD, College of Medicine, Mail Location 182, Cincinnati, Ohio 45267-0182, 513-872-4043.

OHIO: Full-time emergency department position available in a moderate volume teaching hospital located in northwest Ohio. For this exceptional opportunity candidates must have emergency room experience and be residency trained in any specialty. Position offers excellent compensation and malpractice insurance. Please send CV to Debbie Hibberts, EMSA, 8200 West Sunrise Blvd., Bldg. C, Plantation, Florida 33322, or call 305-472-6922.

ORTHOPAEDIC SURGEON (board certified or eligible) is wanted to gradually assume all of a well-established (34-year-old) practice located in downtown Dayton, Ohio, in a specially designed medical suite for orthopaedics. Most surgical procedures will be referred by the established physician to the new physician. This is a ready-made opportunity. Please phone or write if you are interested. H. Clay Messenger, Jr., MD, 233 Northview Road, Dayton, Ohio 45419, phone (513) 293-9023.

OPPORTUNITY TO JOIN SMALL GROUP OF EMERGENCY MEDICINE RESIDENCY trained physicians in Southern Wisconsin staffing community hospital with 20,000 patients/year. Good pathology, stable contract, excellent support. Seeking emergency medicine BC/BE physicians with ACLS, ATLS preferred. Remuneration/benefits highly competitive and commensurate with training and experience. Contact: John J. Maher, MD, Director, Department of Emergency Medicine, 1969 West Hart Road, Beloit, WI 53511, 608-364-5682.

PENNSYLVANIA: Unique opportunity. Building new emergency department in progressive, academic community hospital. New facility, in-the-round. Base station, active paramedic training program, resident education. Opportunities for research and teaching affiliation with nationally prominent emergency medicine residency program. Competitive salary with paid malpractice, disability, life insurance, CME, etc. Emergency residency trained, board certified, or board qualified and actively seeking certification. Contact Nathan C. Schafer, MD, Chairman, Department of Emergency Medicine, St. Margaret Memorial Hospital, 815 Freeport Road, Pittsburgh, PA 15215. (412) 784-4189 or 4782.

PHYSICIAN

Apple Creek Developmental Center is in need of a full-time physician licensed in the state of Ohio. The Center provides comprehensive care for mentally retarded/developmentally disabled individuals in an interdisciplinary team setting. Interest in working with multiple physical and/or emotionally handicapped individuals is required. Excellent salary and fringe benefits. Apple Creek is located six miles east of Wooster and approximately thirty-five minutes from the Akron/Canton area. Send resume to David M. Gall, Director, Human Resources, Apple Creek Developmental Center, 2532 South Apple Creek Road, P.O. Box 148, Apple Creek, Ohio 44606, or call (216) 698-2411, ext. 429. AN AFFIRMATIVE ACTION/EQUAL OPPORTUNITY EMPLOYER.

PHYSICIAN NEEDED FOR HEALTH SERVICE. Excellent opportunity for physician who is board eligible or board certified in family medicine, internal medicine, or pediatrics and who is willing to do gynecology in an accredited multispecialty university health service. Must have doctor of medicine degree and license to practice medicine in the state of Ohio. Comprehensive fringe benefits, excellent facilities, and competitive earnings. Contact D.I. Charles, MD, Director, The Ohio State University Health Service, 1875 Millikin Road, Columbus, OH 43210. An Equal Opportunity Affirmative Action Employer.

POSITIONS FOR FULL-TIME AND PART-TIME PHYSICIANS for urgent care centers in the Youngstown area. Flexible scheduling available for day and evening shifts, weekdays and weekends. Please send CV to P.O. Box 91666, Cleveland, Ohio 44101-3666.

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URGENT CARE CENTER AND ER PHYSICIANS — CLEVELAND, OHIO Our caseload is up. Medical Emergency Services operates freestanding urgent care centers and staffs hospital emergency rooms. We operate three successful Immediate Medical Care urgent care centers in the greater Cleveland suburban area. We will be opening two additional centers within the next 12 months.

We offer the opportunity of practicing medicine in a pleasant and supportive atmosphere with an attractive case mix and top notch staff. You work hard, but have regular hours and an excellent salary. We take care of supporting you with staff, equipment, facilities and patients.

After we both have had some experience together, there is opportunity for stock participation in our organization. If you want to concentrate on practicing medicine, and earn a good income without the hassle and expense of running an office, then this can be the opportunity for you.

Please send CV to Medical Emergency Services, Inc., 6133 Rockside Rd., Suite 10, Cleveland, OH 44131, or call 216-642-1400.

Equipment For Sale

FOR SALE: Allyson and Hamilton exam furniture. Reply to J.B. Edelstein, MD (419) 756-6416; (419) 522-2031.

Practice For Sale

ORTHOPEDIC PRACTICE FOR SALE Well established orthopedic practice in Southwestern Ohio with own large office and x-ray equipment. Owner planning to retire. Flexible financing. Reply to Box No. 69, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, OH 43215.

RELOCATE PRACTICE: Looking for a physician to take over present practice, located in a small city of northeastern Ohio, urgent. Reply to Box No. 80, c/o Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

MEDICAL PRACTICE SALES AND APPRAISALS: We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our brokerage division at: The Health Care Group, 500 GSB Building, Bala Cynwyd, PA 19004 (215) 667-8630.

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WEST SIDE CLEVELAND HOSPITAL has openings for house staff physicians in orthopedic surgery beginning January, 1986. House staff are eligible to establish private practices in hospital's medical office building. Apply to Box No. 82, c/o Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

To Dr. Warren W. Smith . . . Here's one from the heart

I'm still not sure which one of us hurts the most.

When I received Dr. Smith's hastily written note stating that poor health was forcing him to resign from the *Journal's* Editorial Advisory Board, I felt a pain go right through me — the kind of sharp, sudden pain that swallows you whole and leaves you gasping for air. Even now, I find myself reeling from its effect.

But I know Dr. Smith. He and I go back a long way — over ten years now — and I know the pain he must have felt upon resigning from both our publication and from the *Bulletin of the Academy of Medicine of Columbus and Franklin County,* which he brilliantly edited for years, must have been even more devastating for him.

You see, in addition to being an excellent internist, Dr. Smith is a wordsmith extraordinaire — as skillful with a pen as he is with a stethoscope. His love and respect for the English language has always lured from him such well-crafted sentences, such thoughtful, hit-em-on-the-head insights, that, upon reading his essays, it is as easy to believe that E.B. White had been sitting at the typewriter as a doctor of medicine. No wonder, then, that he can probably count as many journalists among his friends as doctors — including the editor of the recently defunct *Columbus Citizen-Journal.*

I first met Dr. Smith when I was serving in the same position I am now on the Columbus Academy's *Bulletin.* He quickly became my mentor and my friend. He supported my beliefs that a publication — no matter *who* its audience might be — was meant to be read, and that meant writing as well, as captivatingly as possible. His tastes as an editor, his contributions as a writer have always reflected that — whether it was an essay for the *Bulletin,* a piece for us, or a letter to the editor for one of the local newspapers. (If you've never read his "Year In Review" columns, scrounge up some back copies of the Columbus *Bulletin* and treat yourself.)

When I took over as editor of the *Journal,* Dr. Smith was a natural choice for our Advisory Board. Although his duties as Editor of the *Bulletin* precluded him from getting as involved as I might have wished, the manuscripts he reviewed for us always came back promptly; his suggested topics for our editorial calendar were always timely; and he was always happy to lend his office, his equipment and his office staff whenever we needed "props" for a *Journal* cover. His notes of support and encouragement were never-ending, and always well-timed.

All of us who work on the *Journal* and in the Department of Communications at the OSMA want to send him our thanks, our appreciation and our best wishes.

As for me, I have no intention of retiring Dr. Smith or removing his name from our mast. He will stay on as Editorial Advisor Emeritus. And as an advisor, supporter, mentor and friend, he will stay in my heart forever.

— *Karen S. Edwards*

In Memoriam

Warren W. Smith, MD, died on January 1, 1986.

There is little that I can add to the thoughts I expressed here before his death, except to say that the world of medicine and journalism both will miss the skill, the insight and the years of experience and caring he brought to both professions.

. . . And I shall miss him very much.

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In recurrent urinary tract infections

Highly effective against a wide range of susceptible uropathogens:

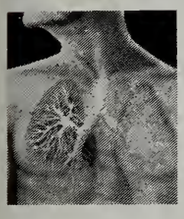
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In acute otitis media in children

Clears middle-ear fluid of the most common susceptible pathogens:

Streptococcus pneumoniae
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(even ampicillin-resistant strains)



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Clears the sputum of important susceptible pathogens:

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Not indicated for prophylactic or prolonged administration in otitis media at any age; contraindicated in infants less than two months of age.

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Effective and versatile *b.i.d.* therapy

Before prescribing, please consult complete product information, a summary of which follows:

CONTRAINDICATIONS: Hypersensitivity to trimethoprim or sulfonamides; documented megaloblastic anemia due to folate deficiency; pregnancy at term and during the nursing period; infants less than two months of age.

WARNINGS: FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently.

BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS:

General: Give with caution to patients with impaired renal or hepatic function, possible folate deficiency and severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur, frequently dose-related.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently; if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffé alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenesis: Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. *Mutagenesis:* Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. *Impairment of Fertility:* No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folic acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS and CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).** *Hematologic:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, methemoglobinemia, eosinophilia. *Allergic Reactions:* Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. Periarteritis nodosa and systemic lupus erythematosus have been reported. *Gastrointestinal:* Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. *Genitourinary:* Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. *Neurologic:* Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. *Psychiatric:* Hallucinations, depression, apathy, nervousness. *Endocrine:* Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. *Musculoskeletal:* Arthralgia, myalgia. *Miscellaneous:* Weakness, fatigue, insomnia.

DOSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN: *Usual adult dosage* for urinary tract infections is one DS tablet, two tablets or four teaspoonfuls (20 ml) *b.i.d.* for 10 to 14 days. Use identical daily dosage for 5 days for shigellosis. *Recommended dosage for children* with urinary tract infections or acute otitis media is 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses every 12 hours for 10 days. Use identical daily dosage for 5 days for shigellosis. *Renal Impaired:* Creatinine clearance above 30 ml/min, give usual dosage; 15-30 ml/min, give one-half the usual regimen; below 15 ml/min, use not recommended.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS: Usual adult dosage is one DS tablet, two tablets or four teasp. (20 ml) *b.i.d.* for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS: Recommended dosage is 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

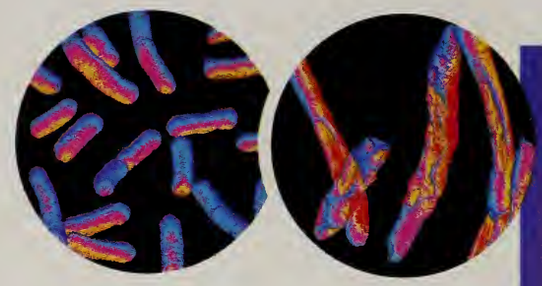
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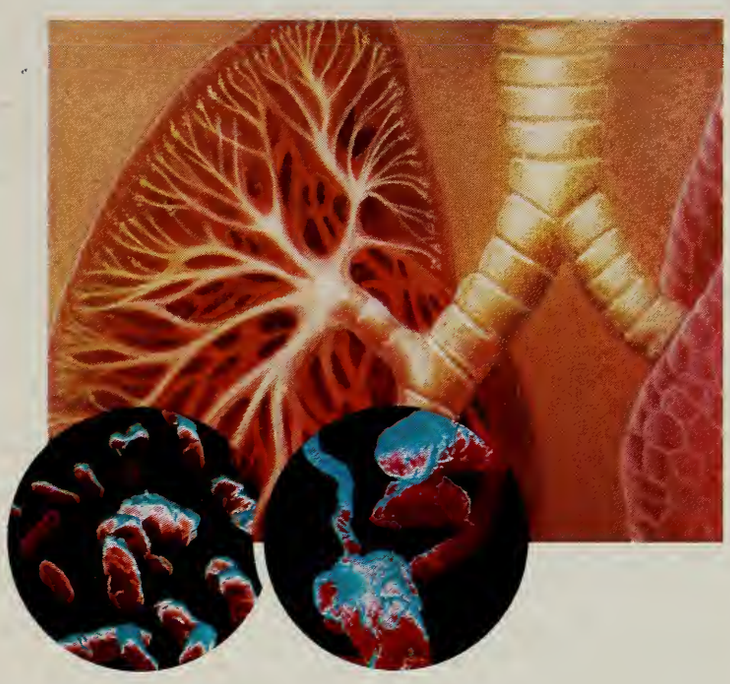
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before Otoscopic view of tympanic membrane in a patient who did not respond to ampicillin therapy.

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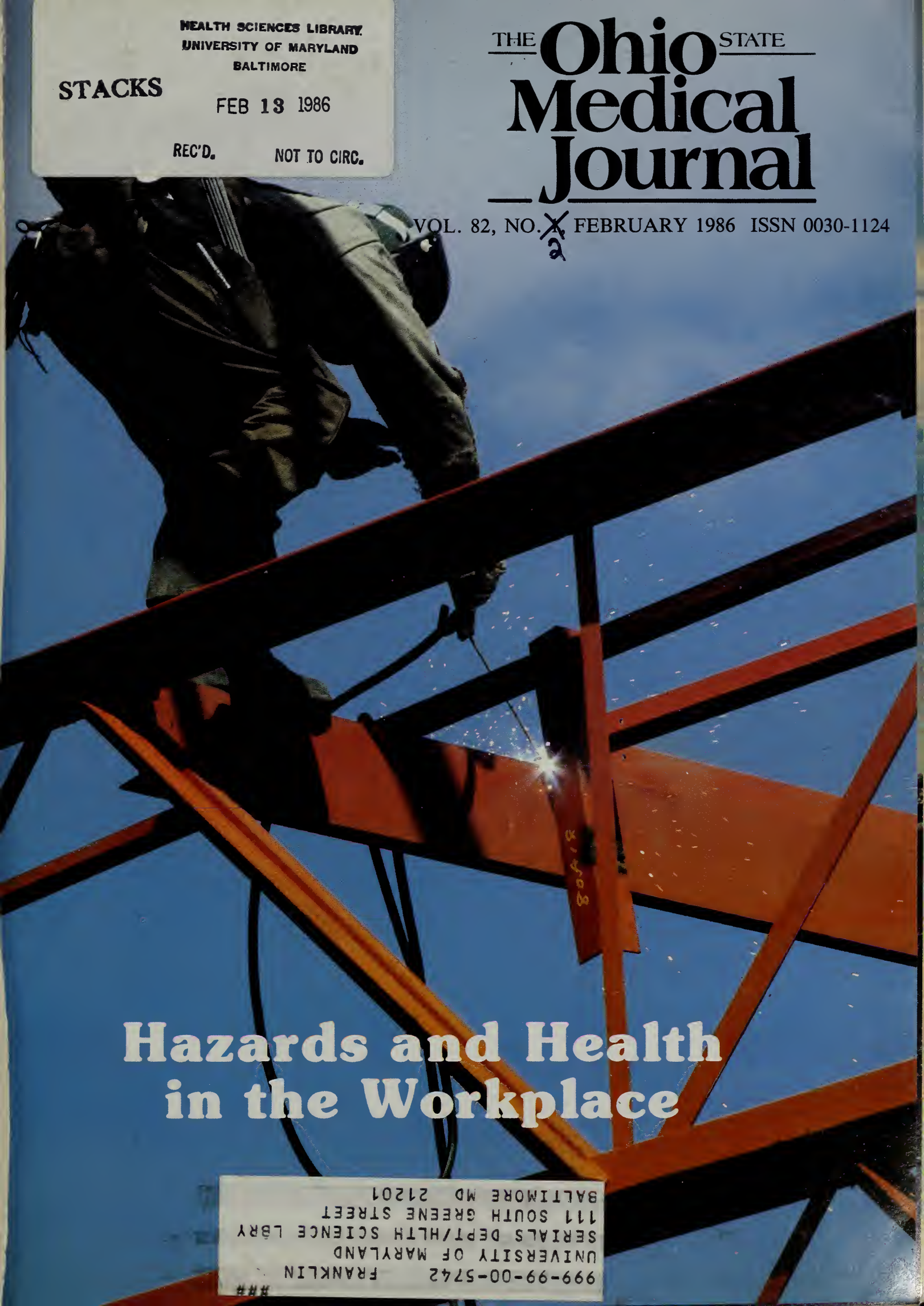
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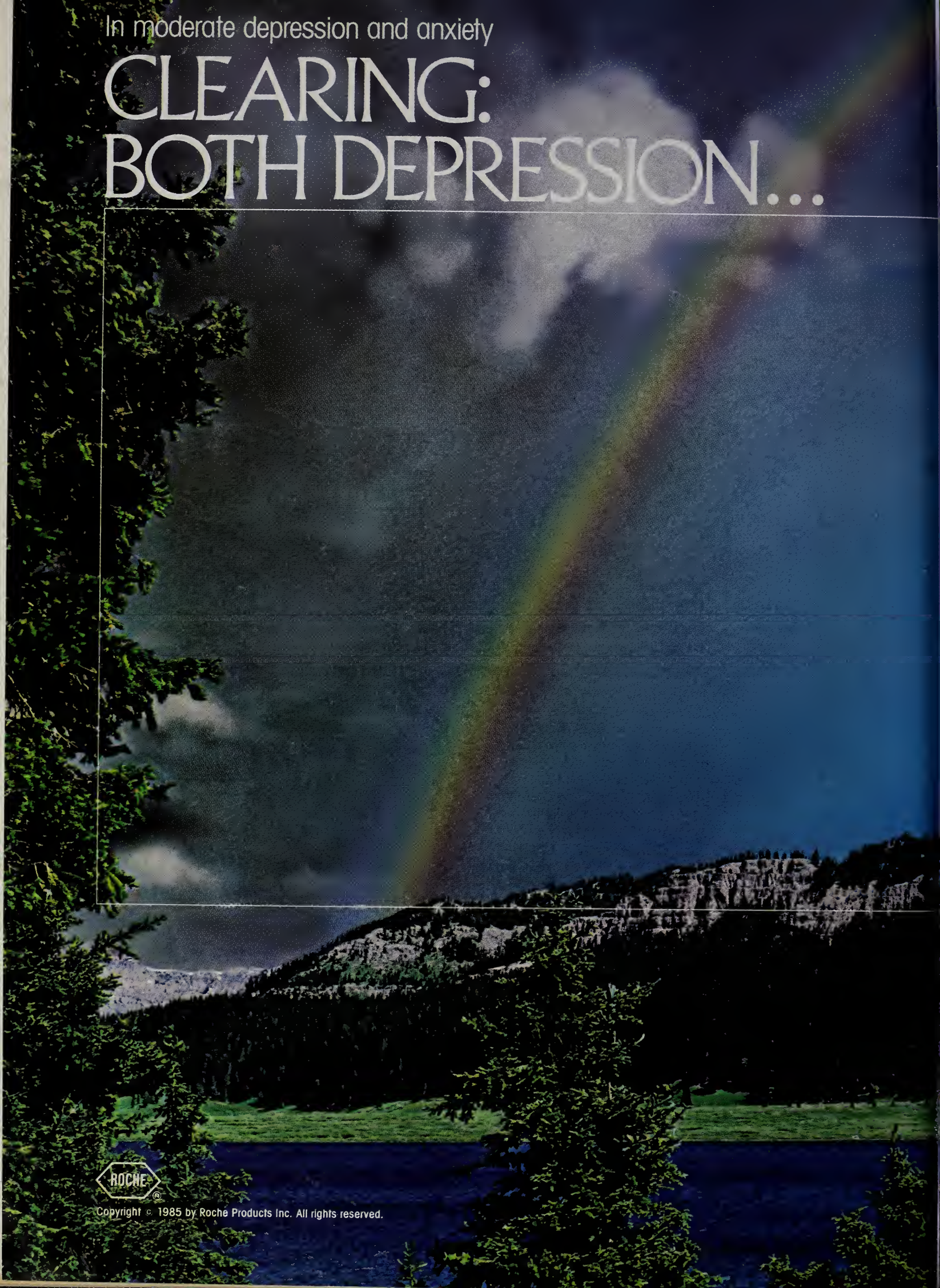
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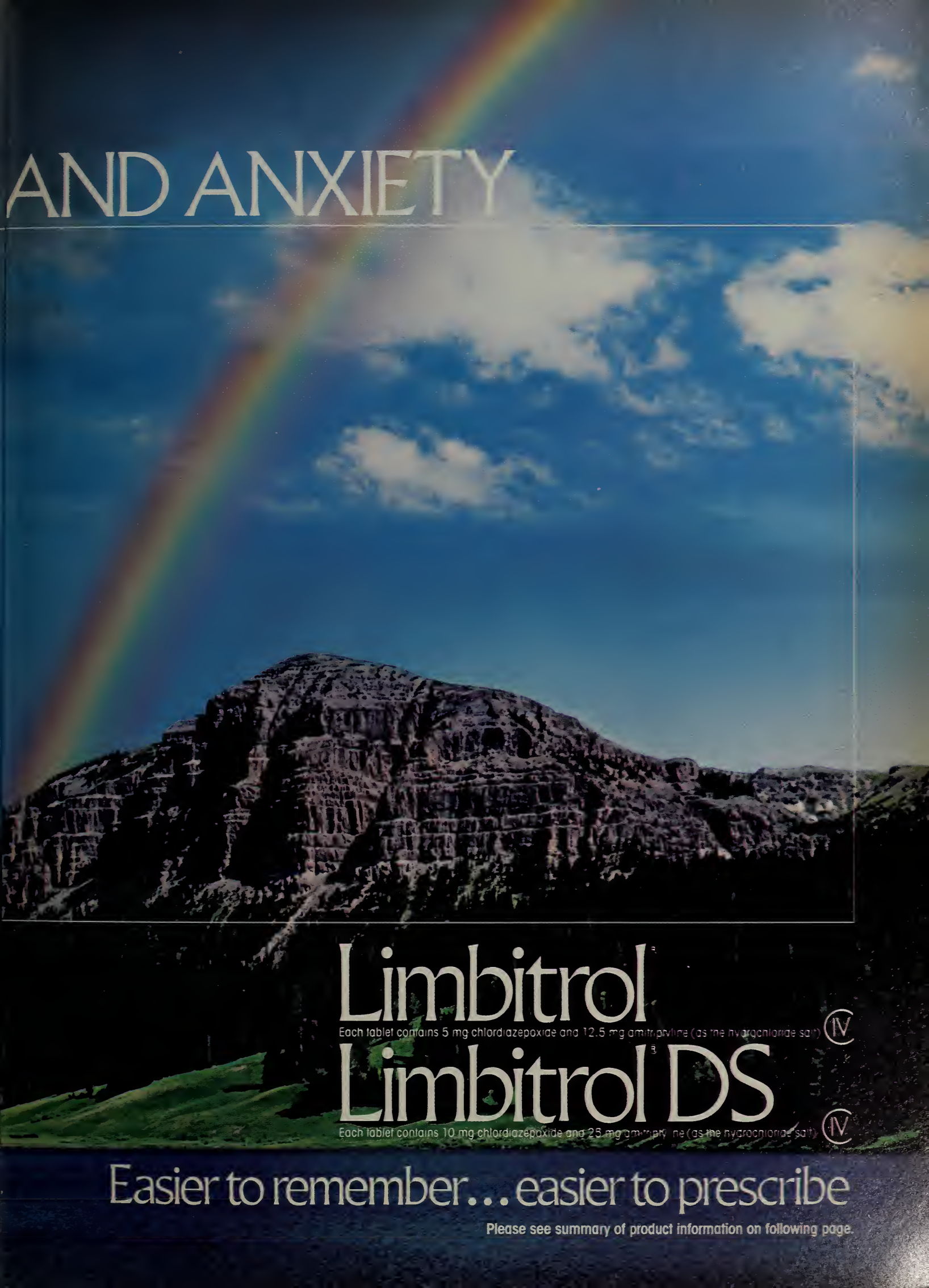


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Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
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Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
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Herman I. Abromowitz, MD

-PRESIDENTIAL PERSPECTIVES-

Regulation vs. Competition

When we became physicians, we all pledged to ourselves and our patients to practice medicine to the best of our ability.

I personally am honored when patients entrust their care to me. I therefore simply cannot do less than my best in fulfilling the trust of my patients.

I firmly believe that virtually all physicians uphold this same oath of caring and responsibility. This allegiance of integrity has made our health care system the best in the world. As physicians, we *must not* and *will not* sacrifice quality of care.

But there are two forces operating in the health care environment today which have a direct impact on quality: competition and regulation. These two factors have been examined and discussed at length by health care professionals and others nationwide. Just recently I served on a panel gathered by the Ohio Association for Areawide Health Planning to once again examine the issue of competition versus regulation (see related Medi-scene). One thing became clear as I listened to panelists gathered that day: there are as many points of view on this subject as there are panelists willing to address it.

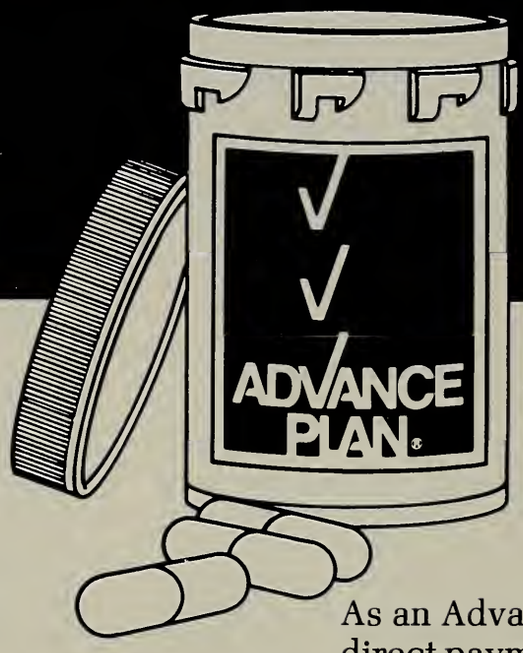
From my point of view as a practicing physician, competition and regulation are not and never will be compatible. Patients will indeed suffer as a result of this discrepancy present today in our health care environment. I think that everyone agrees that medicine has and will continue to handle competition. After all, as physicians, we compete for patients daily. This competition is a healthy exercise for all concerned — patients and physicians alike. However, what I cannot support in any way is unfair competition. When federal or state governments subsidize certain health care entities in the name of lowering health care costs, it is creating an unfair advantage. As a private practitioner, it is difficult for me to compete with providers who are given an unfair advantage by outside forces through subsidies, assistance and other preferred treatment.

As to regulation, I have serious concerns regarding the effect overregulation will have on quality of care. Everyone realizes that some regulation is necessary in medicine; and I, of course, have no quarrel with state licensing requirements or regulations which are designed to protect patients from illegal or irresponsible health care professionals.

But it is clear that in recent years medicine has become drastically overregulated. A good example is the way in which third parties are seeking to become involved in every aspect of patient care.

During the coming years as the issue of regulation versus competition continues to smolder, physicians must persevere to see that quality of care is never, ever, sacrificed.

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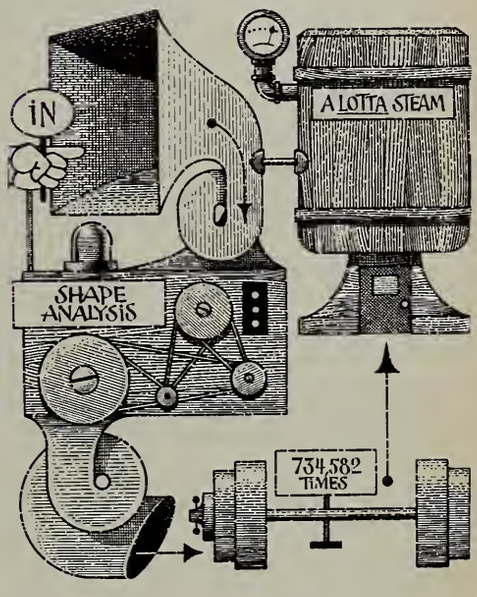
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(b). A copy of the manuscript should be retained by the Author.
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(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. *The Journal* will assume $10 of this expense and the author will be billed by *The Journal* for the remainder.
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Changing Times

On Mondays, my desk usually resembles someone's front lawn after a particularly vigorous autumn rainstorm. News releases are scattered across the top like so many unraked leaves, and only after several hours of reading, sorting, pruning and piling does the whole begin to approach some kind of order.

It was during one of these reading-sorting-piling sessions that a slim white folder with a bold blue nameplate caught my eye. It was the name more than the design that arrested my attention, since prior to reading those clean, white letters, I had never before heard of *Massachusetts Medicine.*

Once inside, however, the folder's contents let me know that *Massachusetts Medicine* is to be the new socioeconomic publication of the Massachusetts Medical Society — the same medical society which prints the prestigious *New England Journal of Medicine.* According to the release, the time was "right for a new publication."

"Although the mission of the physician has not changed, the way he ministers to his patients has been modified. The society that physicians treat is increasingly complex, and its expectations of doctors are correspondingly complicated. We hope to help Massachusetts physicians meet these challenges," says the magazine's new editor.

It's interesting that Massachusetts, which has always been first in presenting the newest clinical and scientific advances, is following a good many other states — including Ohio — in the undertaking of a socioeconomic publication.

Of course, there will always be a need for a *New England Journal,* but what a profound statement the Massachusetts Medical Society is making with its *Massachusetts Medicine.* The times, indeed, are changing.

What a profound statement the Massachusetts Medical Society is making with its Massachusetts Medicine.

This issue, we have taken a brief look at the workplace and how the practice of medicine fits into today's business world of high-technology and even higher stress.

Our lead article takes a look at the hazards which are present in the workplace — the types of illnesses and injuries being seen; how doctors are supposed to treat the injured; and how reimbursement figures into the doctor-patient picture.

Our second related article deals with corporate fitness centers — those sleek, chrome-fitted rooms which allow everyone from high-level executives to low-level support staff a chance to work up a good sweat in the interest of preventive medicine. A number of them are muscling their way across the state — sponsored by hospitals, entrepreneurs, even the companies themselves, and we think it's a trend worth watching.

Our "Physician and Ohio Law" column returns this month, and you'll not only find the OSMA's 1986 budget in this issue, but the audit report on 1984's budget as well.

Unfortunately, holiday schedules prevented us from reaching Councilors in December (our deadline for this issue was extremely tight), but that column will return in March when we take a look at the merging and changing role of interprofessional relationships.

As we make plans for that issue, we can't help but think . . . if *ever* there was a time for Massachusetts to join the rest of us in the frying pan . . . this certainly has to be it. — *Karen S. Edwards*

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Letters to the Editor

Community service and physician image

To the Editor:

This is in reference to the Presidential Perspective published in the September issue, titled "Closing the Image Gap." I have been in practice in Oregon, Ohio for the past 10 years. It is a community of 22,000 people, part of Metropolitan Toledo and Chessie Railroad System. As part of my community service, I have been on the Board of Directors of the Oregon Chamber of Commerce and in that capacity I have resumed the role of community cheerleader and have started many innovative programs to attract new jobs to Oregon and retain present ones.

In 1985, Sun Oil decided to expand and modernize its refinery. Globe Industry, an auto parts supplier company, also decided to expand and Co-Bar, a steel firm, moved into Oregon. We started a Chamber of Commerce Newsletter which highlights the business activity in Oregon. The business community in Oregon is so pleased with my work, that I was reelected President for 1986.

I have also been very active in Oregon Growth Corporation, a nonprofit corporation formed to attract new jobs to Oregon.

I feel that my community service has enhanced physicians' image. I would urge all physicians to get actively involved in such community activities.

Sincerely,
Riaz N. Chaudhary, MD,
President
Oregon Clinic, Inc.
Oregon, Ohio

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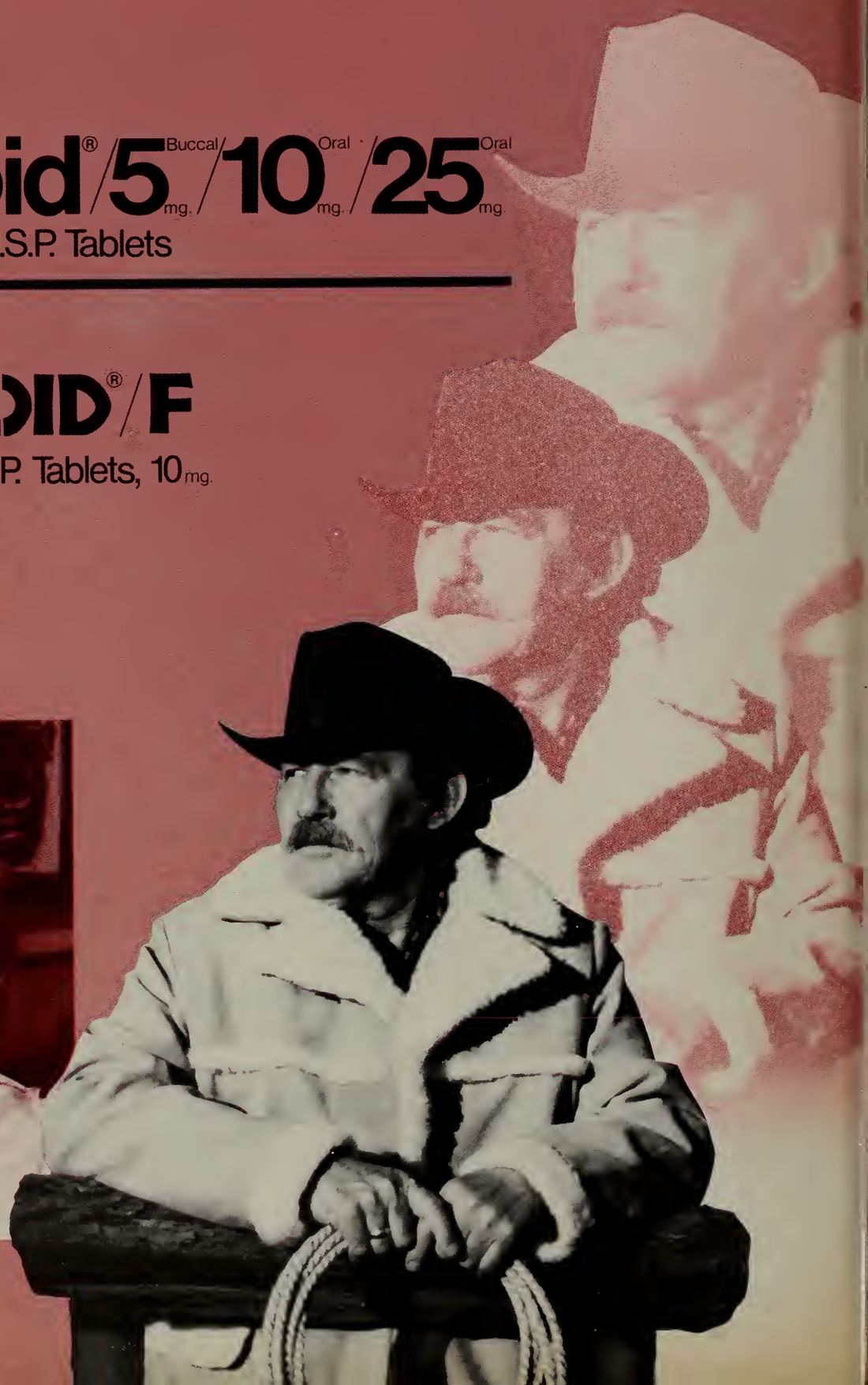
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Where's the Patient? or Business as Usual in Health Care — An Internist's View

By Kenneth L. Wehr, MD

The provision of health care in the United States has become a large business valued at roughly 10% of the gross national product (GNP). Whether this expenditure is appropriate enlivens debates. Involved in this business are at least six categories of players: 1) government and quasi-government agencies; 2) hospitals; 3) physician and other health care providers; 4) insurance companies; 5) various businesses and employers; and 6) patients and consumers. Each of these groups participates in the delivery of health care and at this time are the major controlling forces in the health care business.

The complex interplay of the various involved groups results in our present state of health care. Although some would suggest that market forces are driving us to a new health care system, this should not imply that there is any consensus as to what this new system should encompass. It appears that the purposes of the health care system, that is, the delivery of quality health care to persons living in the United States, has been diluted by the individual needs and motives of these various groups. These various groups foster solutions to the care ideals motivated primarily by individual fiscal concerns.

The concern for quality of care is difficult to discern, although the topic is given vocal commitment by all.

The concern for quality of care is difficult to discern, although the topic is given vocal commitment by all. A discussion of some of these motivations should engender in all participants a further re-evaluation and perhaps can, at least idealistically, lead to a more appropriate health care system which deals first with patient needs. The lack of this reevaluation can lead only to a

more fractured health care system which fails to deal with patient needs.

There seem to be no "heroes" in any of the factions, and a critical look at these various participants should be cause for further analysis by each of the players.

The government and quasi-government agencies seek control of the system in a democratic fashion engineered by tremendous publicity forces. The present modes involve implementing "market place" techniques in the health care field. Unfortunately, the quality of care receives only second paragraph importance. The bottom line is revenue and expenditures. Financial parameters control the system certainly to a larger extent than that which could be compatible with quality of care. Numerous legislative mandates (HMO legislation, TEFRA, PRO) seek to control by financial means the level of care. Perhaps the legislators should review what the bureaucrats have done with their legislative intents. Quasi-government organizations (JCAH, PROs) allow another order of control in the name of quality of care. The cost of these organizations to the total cost of health care will never be known — certainly not financially and definitely not with respect to the quality of care received by the patient.

Hospitals are the central player in the delivery of services. Both for-profit and not-for-profit institutions seek a fair return for their investment. Marketing of services even of marginal value to overall health benefits has become the operating mode. Budgets for advertising are soaring. Services offered are multiplying. Duplication of services are escalating. Each hospital seeks to protect its service area in order to provide adequate patient services to support increasing budgets. The driving force is revenue. The hospital bill resembles a grocery list with charges for services heretofore considered part of the daily charge fee. The increase in the number of complicated corporate arrangements of hospitals provides a means to shelter revenue generating operations.

Physicians and health care providers have adapted to the new rules and regulations, also. Although fees may be controlled (at times, artificially), the methods of billing and collecting has become a new art or business, as it may be. In fact, a whole new industry to educate physicians and office staffs to in effect become better business persons has developed. Even academic center physicians are driven by the business department in many situations. Hopefully, the quality of health care is still most important to the physician, but the climate is such that there are more numerous motivations to play the "business game." Although physicians and the American Medical Association react to various legislative proposals, there is too little concern for the overall quality of care delivered and certainly responses are reactive and not creative, in general.

Hopefully, the quality of health care is still most important to the physician, but the climate is such that there are more numerous motivations to play the "business game."

The insurance business has thrived in the present environment. It has offered the buyer what he seeks, which from a business standpoint is appropriate, yet this industry has contributed to the fractured system. Benefits are subtly reduced by actuarial recommendations to limit expenditures which are then passed on to the buyer as savings. Complex systems are devised to limit reimbursements. Yesterday, the insurance industry was selling "full coverage" policies. Today, reacting to the needs of the purchaser — often large businesses — various systems are devised to limit the expected expenditures, therefore making the product cheaper. Although this is "a goal of capitalistic business," it does not even attempt to deal with the quality of care delivered. Business which originally found it ideal to deliver "full coverage," perhaps as a "carrot" to forestall wage increases, is finding the cost excessive. Therefore, a shifting mode develops. Services purchased are limited; new plans which can limit expenditures are being fostered; bargaining to limit benefit packages is more intense. In this scenario, the bottom line is limitation of expense. The quality of the health care is secondary. Certainly there is a need to control expenses from the business viewpoint, yet there must exist a conscience which somewhere in the formula deals with the care issue.

Patients and consumers, of course, suffer the travails of the various wranglings of the other players. Yet they (i.e. we) are at fault also. We seek first dollar coverage of everything even remotely related to health care (exercise equipment, cosmetic surgery, etc.) and expect to pay less. We consider "comprehensive" health care a right. Perhaps it ought to be a right, but the definition of

comprehensive is variable and dependent primarily on our individual needs and not necessarily on a definition of that determined level of care. We've not been taught health care. Look at the amount spent on vitamins, food supplements, health centers, and unproven modalities of therapy. We quest for life eternal and expect that the health care delivery system will supply that to us in a package neatly wrapped and with little or no individual responsibility or cost.

The system of health care is fractured. There is no true definition of quality of health care, and definitions devised are often based on financial constraints. Each of the players seek support for their individual needs all of course with the carrot — quality of care — dangled somewhere amidst the rhetoric and marketing strategies.

We quest for life eternal and expect that the health care system will supply that to us in a package neatly wrapped . . .

If we fail to develop a more concerted effort to define realistically that health care we seek, our system will decay rather than develop. The issue of quality health care is too important to be driven by players whose motives are self-driven.

Kenneth L. Wehr, MD, is an internist practicing in Hamilton, Ohio.

The *OSMA Journal* welcomes Second Opinion articles from its readers. If you have any position you would like to air, or a viewpoint you wish to express, please let us hear from you: The OSMA Journal, 600 S. High St., Columbus, Ohio 43215.

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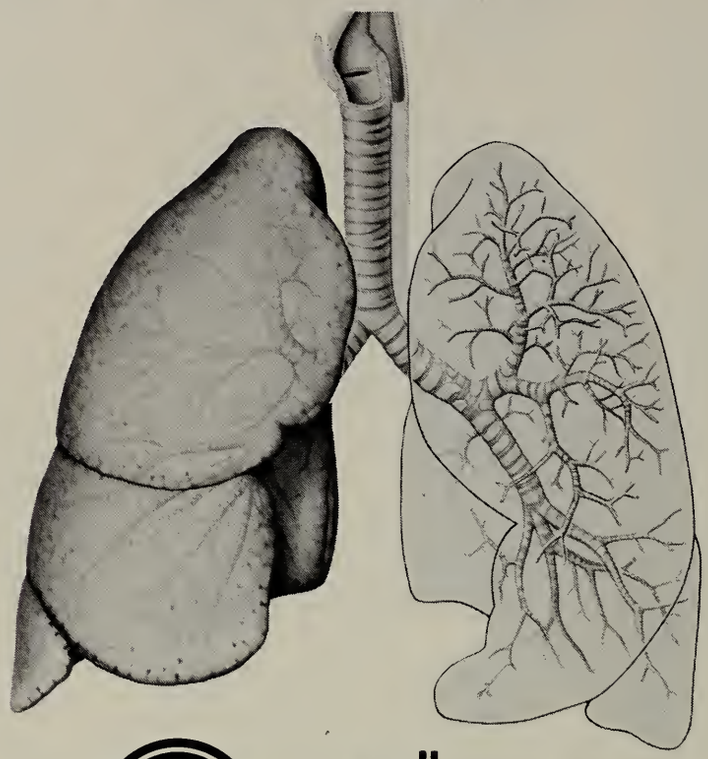
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Brief Summary: Consult the **package literature** for prescribing **information.**

Indications and Usage: Ceclor (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbiliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0617B2R]

Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Ohio medi-scene

Competition vs. regulation ... recruiting success ... linking cholesterol and heart disease in boys ... patient communication

Competition vs. Regulation: A Matter of Degree

Picture a supermarket. Now, would you shop there if:

* It was only open during those hours you worked?

* You had to make an appointment to shop there?

* You had no idea how much each item would cost prior to reaching the check-out line?

Probably not, says George L. Atkins, Vice President of Public Affairs for Humana, Inc., Louisville, Kentucky.

Atkins was one of a panel of experts, gathered by the Ohio Association for Areawide Health Planning, Inc., for the purpose of discussing "Competition vs. Regulation in the Health Care Field."

Competition, says Atkins, has evolved naturally from a trend that has pushed the provider out of the driver's seat, and placed the consumer in charge.

"Consumers now want to take control of their own lives," Atkins says. "They no longer want others making decisions for them."

So the traditional system of health-care delivery has been changing to meet their needs — not just for more information, but for lower costs as well.

"The whole focus of the industry now is to keep patients *out* of the hospital instead of putting them in," Atkins says. It is also the reason regulations like the prospective payment system have begun to appear.

"With 10, 20, 30 percent escalation in costs, people finally said 'that's enough.' " And Atkins doesn't see the focus changing anytime soon.

"Eventually, quality control will surpass the need for price control," he predicts, but a lot will happen before this turn-around takes place.

"In the future, we'll see 90 percent of the health care in this country being delivered by contractual arrangement," he says. Doctors will join groups and hospitals will become part of systems — not only to provide bigger and better services, but for self-preservation as well.

Despite the cost savings already realized by competition, however, Atkins admits it's not really the answer to health care's ills. Too many problems are already falling out that need to be addressed, he says — big problems like research, education and indigent health care.

So is regulating health care the answer?

Not entirely, says James R. Kimmey, MD, President of the Institute for Health Planning, Madison, Wisconsin.

"We are hunting for a balance between the two — a regulated competition."

Competition, however, is not necessarily providing the consumer with the information he or she is seeking, says Dr. Kimmey.

"The slick TV commercials we're all seeing are selling the sizzle of health care. They're images only. The consumer has no idea of the quality or price of these facilities."

Nor can competition really claim any credit for the changes that have been occurring in hospitals — the fewer admissions and the shorter lengths of stay. That is due to regulation — more precisely, the government's prospective payment system.

"But how much regulation do we need?" Dr. Kimmey asks. Are DRGs, CONs and PROs stretching regulation too far?

"We can't completely throw out planning and regulation," says Dr. Kimmey. But a balance between the two is what is needed.

"Regulated competition is where we will be going in the future," he says.

Comments from other panelists on this subject include:

Ohio medi-scene ... continued

Competition vs. regulation ... *continued*

David L. Jackson, MD, Director, Ohio Department of Health — "Health care has been asked to adjust to a new focus in a very short period of time. What is needed is a balance between competition and regulation, and an adequate information base which will allow us to come to grips with cost, quality and access to care."

David S. Abernethy, President, American Health Planning Associates, Washington, DC — "What happened is that desperation — not competition — has set in on the decision-makers and health-care buyers. The people who pay the bills began asking why costs are going up. The government heard them and came up with one of the most regulated forms possible — the prospective payment system. But the real issue has come down to *who* will make the health care decisions in the future."

Herman I. Abromowitz, MD, President, Ohio State Medical Association — "Competition and regulation are not compatible — patients will suffer as a result. Medicine can handle competition. We compete daily, but we cannot support unfair competition or a decrease in the quality of patient care. Limiting or rationing care is not the American way."

Frank Armstrong, Vice President, Goodyear Tire and Rubber Company — "Several years ago, we realized our own purchasing power, and at the same time realized that there was an absence of information about the vendors who delivered the health-care services to our employees. Before, there was always a 'what me worry' attitude on the part of the employees, because third-party and other payors were involved. Now consumers are getting involved and making decisions on information they're receiving. If prices go up as a result of that rational decision-making, then so be it."

Robert E. McGarrah, Jr., Director for Public Policy, AFSCME/AFL-CIO, Washington, DC — "Information is essential in the delivery field. What kind of consumer information is available, however? There are few directories or other sources of information that will tell the consumer who is practicing high-quality medicine. There is a quality of fairness involved however. Consumers have the right to know who might be harmful to them, but they have no way to get this information. In a healthy, competitive environment, this information would be available to them."

Donald R. Newkirk, President, Ohio Hospital Association — "Health care needs a mixture of both competition and regulation, but a pinch too much of either will ruin the dish. It's true that regulation has stood hospitals in good stead, but competition is something hospitals have been thrust into. We're new in the business of competition, but we're quick studies. Still we don't know yet how much is enough, and how much is too much."

Joseph Tomasi, Director, United Auto Workers, Northwest Region — "When we talk about deductible and co-payments, we are shifting the focus of who pays onto someone else, and this has helped to awaken public interest in health care costs. Problems arise however when we are dealing with part-time, low-wage workers, the indigent and the elderly. The Medicare payments, for example, are more than most retirees can afford, so the elderly are buying insurance to cover themselves. Most of these policies, however, are not worth the paper they are written on, and that is when major problems arise. Second opinions, pre-admission testing, and outpatient surgery are stemming the price of health-care costs, but when costs are the bottom-line factor, health care suffers. It seems we can no longer afford the quality of health care that is our right." — *Karen S. Edwards.*

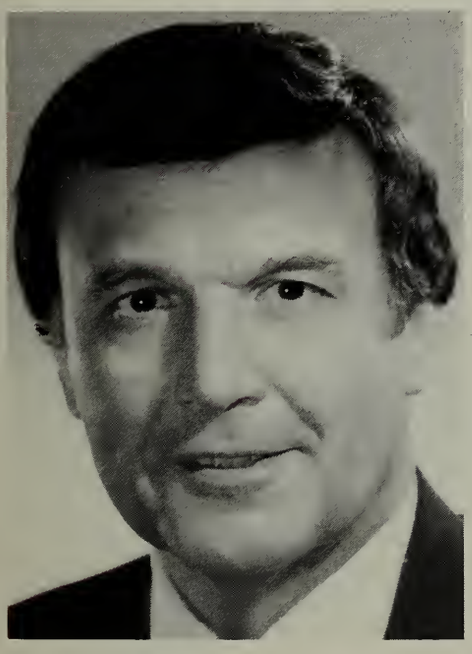
Trumbull County Medical Society Announces 1986 Officers

The Trumbull County Medical Society has announced its officers for 1986. They are:

President — B. Joseph Tabet, MD

President-Elect — Paul G. Zerbi, MD

Secretary-Treasurer — Frank P. Vargo, MD



Dr. Baumgartner wins recruiting award

Donavin A. Baumgartner, Jr., MD, Cleveland, Fifth District Councilor, was awarded a special AMA Membership Blazer for successfully recruiting 27 new AMA members through participation in the AMA's Annual Physician Outreach Program. The award was given at the AMA Interim Meeting in Washington, D.C.

Dr. Baumgartner placed second in a group of 15 physicians who received blazers. The winner recruited 29 new members.

Ray W. Gifford, Jr., MD, Cleveland, was one of 27 physicians who received a Physicians Outreach Tie for his participation in membership recruitment.

In addition, six Ohio medical students took top honors for recruiting the most AMA student members. These students were: University of Cincinnati: Rich Bahner, Steve Gilreath, Judy Lavrich; Medical College of Ohio at Toledo: Brian Jewell, Joel Gleman; and Ohio State University College of Medicine, Cathy Yeagley.

The students and their respective medical schools received plaques commemorating their achievement.
— *Carol Wright Mullinax*

Linking cholesterol and heart disease in adolescent males

Adolescence has always been the time when the level of high density lipo proteins — the so-called "good" cholesterol which sweeps excess cholesterol from the bloodstream — begins to decrease in males, leaving them with a high level of low density lipo proteins, which are thought to be associated with heart disease.

It is this fact which, for years, has prompted the medical profession to look at cholesterol as a significant indicator of heart disease.

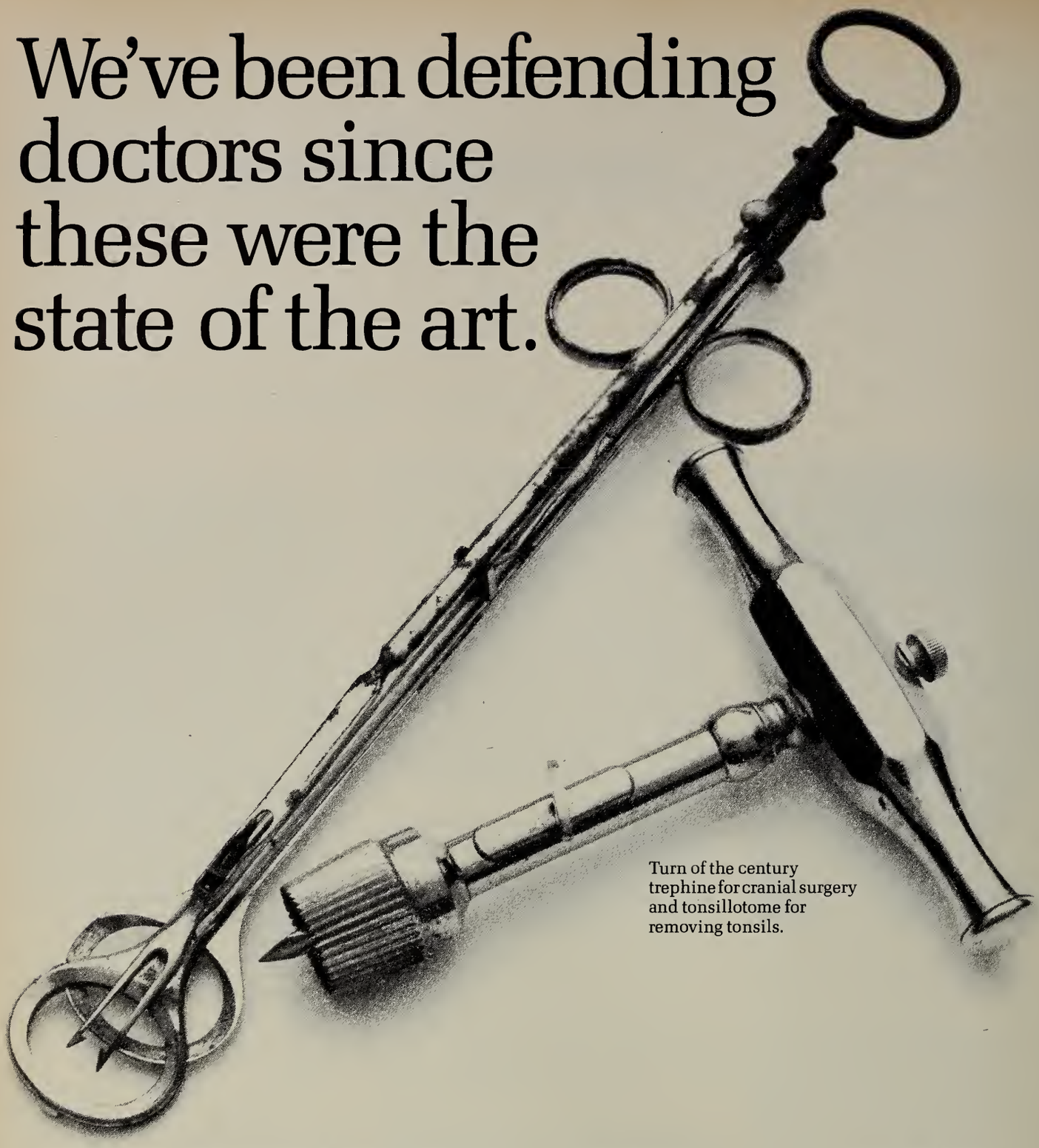
That's why John Morrison, an associate professor of epidemiology at the University of Cincinnati Medical School, has recently launched a two-part study to examine cholesterol levels — specifically, the ratio between high density lipo proteins and low density lipo proteins — in adolescent males in the Cincinnati area. He is also studying specific factors which influence cholesterol levels and, consequently, predispose certain individuals toward a greater risk of early heart disease.

Males and females have the same respective levels of low density and high density cholesterol proteins until adolescence, Morrison says. At adolescence, cholesterol levels in women, generally, reach a plateau and remain relatively fixed throughout their lives.

The scenario for males, on the other hand, cannot be drawn so evenly, according to Morrison. During adolescence, males, "on the average, experience a decrease of roughly 20% of their level of HDL (high density lipo proteins)," he explains.

Morrison set out to determine whether a decrease in "good" cholesterol was an "inevitable, unavoidable fact of maturation" for males in adolescence. He began by recording hormonal, weight/height and cholesterol ratios in 500 males between the ages of 10 and 14 to determine

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Linking cholesterol and heart disease . . . *continued*

what role these factors play in early heart disease. What he is learning is that there is a pattern emerging — linking the factors he is recording with an increased risk of early heart disease.

One of these factors, the ratio between a male adolescent's height and weight, appears to play an important role, Morrison says. Quite simply, the leaner a male is during adolescence, the less likely it is that his "good" cholesterol will be pared down. "In general, HDL (high density lipo proteins) levels move the opposite way obesity does . . . slender people generally have higher levels of HDL than obese people," he explains.

Morrison says that his studies also show that those males with lower levels of HDL display "different hormonal patterns" than the other males tested — especially, a higher ratio of estrogen to testosterone," he claims. Ironically, women, who generally have a higher ratio of estrogen to testosterone, have higher levels of HDL as a group than men.

According to Morrison, heart disease "tends to run in the family both vertically (from parent to child) and horizontally (from brother to sister)." For this reason, he also tested a second group of males — in the same age group — whose families have a history of heart disease.

While this study is ongoing, Morrison says this group shows a proclivity — such as a higher ratio of LDL to HDL proteins — toward a higher risk of heart disease. "My thumbnail sketch, my immediate impression, is that the second group does have a lower level of HDL," he concludes.

Morrison will continue to track cholesterol data from these study groups for an additional two years. In the meantime, he suggests that preventive measures for both men and women — such as regular physical activity, low cholesterol diets, and no smoking — are the best bets for keeping early heart disease at bay. — *Deborah Athy*

Newsletters help with patient communications

Do physicians spend enough time with their patients discussing ideas about treatment and maintaining a healthy life style? You might think so, but survey results suggest that over fifty percent of the public disagrees. Patients want information, but with a full waiting room, how can physicians devote more time to communication?

One solution may be providing information in the form of patient newsletters. Marketing and practice management experts agree that patients give high marks to physicians who distribute personalized health information. And since physicians have little time and staff to undertake such a project, the OSMA offers a service to make the job very simple.

The OSMA produces *Health Hints,* a quarterly patient education newsletter available for personalization and distribution by physicians. Currently, thousands of copies are distributed every quarter by physicians throughout Ohio and the country to patients who want the latest news about staying healthy.

Each issue of *Health Hints* offers a variety of health information pertinent to season (winter, spring, summer or fall), plus current articles about the socioeconomic trends of medicine. Each copy of the newsletter is imprinted with the physician's name or group name and address, and can be distributed with patients' bills, through the office, or by using the self-mailing blank on the newsletter.

Besides providing patients with current information, subscribing physicians are using the publication to enhance their practice in other ways. Distribution to school libraries, local employers, pharmacies, Welcome Wagon, nursing homes, adult day care centers, and at speaking engagements are just some of the ways that the newsletter can be used as a marketing tool.

The newsletters are available in quantities of 200 or more per quarter at a cost of $25 per hundred on a yearly (four quarter) subscription. For ordering information, watch for the February issue of the *OSMAgram* or contact the OSMA Department of Communications. — *Doug Evans*


EMPLOYEES

Hazards in the Workplace

By Susan Porter

Each Monday morning, hundreds of thousands of Ohioans get up, brush their teeth, shower, get dressed, eat breakfast, get in their cars and drive or catch a bus to work. They are involved in a wide variety of occupations and industries, ranging from mining, construction and manufacturing to finance, insurance and real estate — reflective of a state traditionally rich in both natural resources and human enterprise.

For the majority of Ohioans, the work environments they enter each day are relatively safe and hazard free, thanks largely to standards set at the federal level and regulated and monitored through the Occupational Safety and Health Administration (OSHA). Still, if past experience is any indication, some 2.5% of this state's residents will receive more than a paycheck and some benefits for the work they do during 1986.

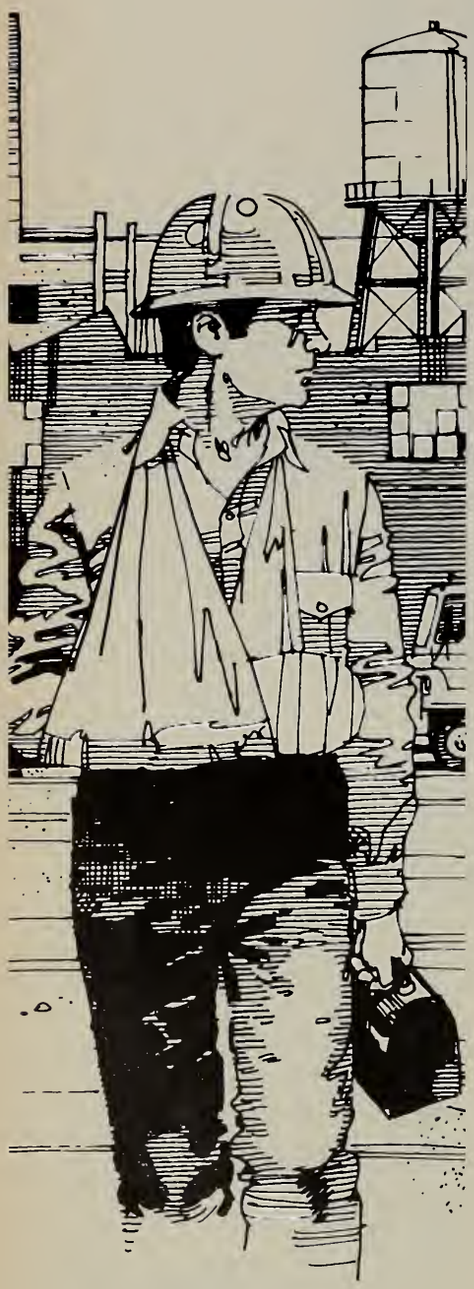
Approximately one out of every 40 Ohioans will suffer from some sort of job-related illness or injury this year, and as many as .2% will die from those illnesses or injuries. And it is not just the workers' problem. Over $818 million was paid out of Ohio's Workers' Compensation system both for medical payments and lost wages during 1984, putting a heavy strain on the budgets of employers who pay premiums to support the system.

It is also an issue that affects a growing number of physicians who increasingly are seeing patients with strange and unusual skin conditions, respiratory problems, joint and tendon inflammations and other disorders which may or may not be related to the work those patients do. And it is physicians who are often asked to help decide the extent of the illness or injury, in order to determine if and how much an individual should be compensated.

According to figures compiled by the Ohio Industrial Commission and the Bureau of Workers' Compensation, the state agencies which oversee the health and safety of Ohioans in the workplace and financially compensate those who get sick or hurt on the job, some 111,772 Ohioans suffered illnesses or injuries from their work severe

Hazards in the Workplace

continued



enough to keep them off the job for at least one day during 1984. Despite efforts at both the state and national levels to improve and upgrade working conditions, that figure represents an 8.6% increase over "lost-time" cases during 1983.

Part of the reason for the increase is the rise in the overall rate of employment in Ohio during the past two years, those who collect and analyze these statistics believe. For example, "there was a slight decline (in the number of Workers' Compensation Claims filed) during the recession," explains John Lucid, statistics supervisor for the Bureau of Workers' Compensation, which both collects and pays out those funds which cover medical bills and lost wages for those impaired in the workplace.

The year 1984, however, saw a 3.2% increase in the state's employment rate, marking a return to the steady rise in claims experienced prior to the 1979-1983 recession. Not only does an increase in the workforce mean a larger number of candidates are exposed to danger or harm; it also means there are a lot of new workers on the job who may not have the skills or experience needed to properly handle the vehicles, machines, equipment, tools, hot or flammable substances, chemicals, dusts and other materials, work surfaces, furniture, fixtures, containers, etc., that can lead to accidents and diseases in the workplace.

"Current research suggests that a greater risk of injury exists for workers during their first few months of employment," says the August 1985 issue of the *Ohio Monitor,* a monthly publication put out by the Industrial Commission. "Also, employment has increased in the traditionally more hazardous industries."

Historically, the mining and construction industries have posed the greatest amount of risk to Ohio workers, followed by manufacturing, transportation and utilities. The least risky are basically the white-collar industries: finance, insurance and real estate, followed by the services (teachers, health care workers, etc.) and the trades, both retail and wholesale.

Not surprisingly, nearly three out of four workers injured or ill on the job are male, due to the high ratios of men in those high-risk areas of work, Lucid says. With greater numbers of women taking traditionally all-male jobs, however, those figures could change.

In addition, greater attention is now being given to potential hazards in white-collar or office work environments. A recent article in the *New York Times* points to contaminated air, hazardous noise levels, inadequate lighting, radiation and microwaves from electronic equipment, and even stress as potential causes of injury and illness in the modern office building. Of particular concern are the adoption of energy-efficient measures which reduce fresh air intake into these office environments, resulting in the buildup of toxic substances and bacteria in the environment.

"The toxic agents commonly found in air samples in such buildings include vinyl chloride, asbestos, formaldehyde, toluene, ammonia, nitropyrenes, PCBs, randon, cadmium and a host of other toxic agents," the article states. As a result, patients may suffer from a variety of illnesses, from hypersensitivity pseumonitis

to Legionnaire's Disease.

Even with its notable increase in Workers' Compensation claims during 1984, Ohio still remains well below the national average in the number of private sector work-related injuries per 100 workers, according to figures kept by the Bureau. Part of Ohio's safety record can be attributed to the Industrial Commission itself, and its Division of Safety and Hygiene, formed in 1925 with the purpose of investigating, researching and preventing accidents, illnesses and injuries in the Ohio workplace.

According to Cliff Timbrook, manager of statistics and research for the Division of Safety and Hygiene, these projects and programs are funded by setting aside 1% of Workers' Compensation premiums for prevention. The monies are used for the development of a variety of safety, educational and prevention programs and publications made available to businesses throughout the state, as well as to employ safety consultants, engineers, industrial hygienists and others who investigate problems in the workplace.

In spite of all efforts to improve safety, however, some 263 Ohioans died from their work during 1984, and another 978 were involved in accidents resulting in permanent dismemberment or disfigurement, including 949 amputations of fingers, toes, feet, hands, arms and legs. Most of these amputations were the result of accidents with presses, saws and cutting and slicing machines, although trucks, tractors, elevators, cranes and conveyors were also involved.

While amputations resulted in the greatest number of lost work days per victim, by far the most common injury sustained at work during 1984 were strains — due largely to overexertion: lifting, pulling or pushing objects or equipment beyond the limits of the worker. Some 26,530 cases of overexertion occurred during 1984, according to the *Monitor,* representing nearly one out of four of the total cases of injury or illness reported last year.

Slips and falls accounted for another quarter of all injuries at work, while flying or falling objects caused 19% of work-related injuries during 1984. Among the most serious and debilitating injuries were those sustained when workers got caught in, on or between a piece of machinery or equipment.

Next to strains, lacerations and punctures were the second most common type of injuries suffered at work, accounting for 14% of the cases during 1984, while fractures (11.6%) and contusions (11%) and occupational illnesses of all sorts (7.1%) followed.

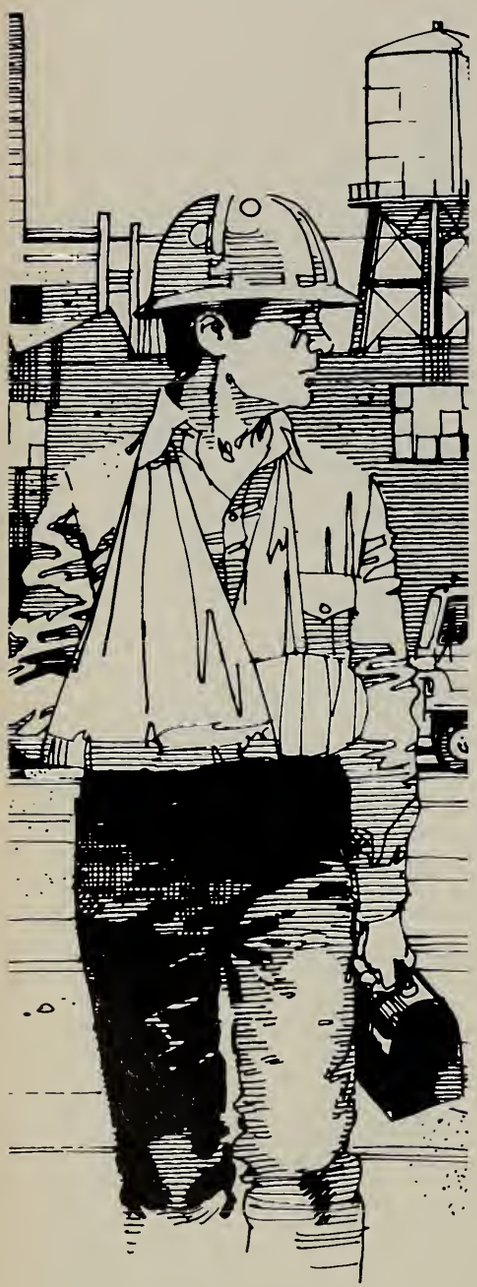
The back was that part of the body most commonly injured, representing 19% of all work-related injuries last year, followed by the legs (13.5%), fingers (12.8%), the trunk and internal organs (10.8%), the arms (9.8%), the feet and toes (6.1%), and the eyes (5.1%).

The 1984 statistics indicate that there were 7,901 cases of occupational illnesses, over 40% of which involved inflammation or irritation of the joints and/or tendons, mainly tenosynovitis and bursitis. Conditions such as carpel tunnel syndrome, a swelling in the carpel tunnel area due to repetitive use of the hand in certain occupations, increased to such an extent that a separate category has been created to track these



Hazards in the Workplace

continued



statistics.

Systemic poisonings accounted for another 18% of the occupational illnesses recorded during 1984. Dermatitis cases, which accounted for 12.5% of the total cases, were also given a greater degree of attention in recent months, along with pneumoconioses, caused by an accumulation of dust in the lungs (139 cases), asbestosis, caused by asbestos dust (45 cases), and silocosis, caused by silica dust (37 cases).

While much attention has been drawn in recent years to the influx of chemicals and other dangerous or toxic substances in the workplace, only 4.2% of the occupational illnesses and injuries reported to the Bureau during 1984 were the result of contact with harmful substances. Accidents were more likely to be caused by other kinds of materials, working surfaces, containers, furniture, fixtures, vehicles, machines and hand tools.

However, potentially hazardous chemicals, dusts and other harmful substances in the work environment remain areas in need of further study, with health experts predicting they could account for an increasing number of worker-related illnesses and diseases in the future.

For example, the National Institute for Occupational Safety and Health (NIOSH), a division of the Centers for Disease Control in Atlanta, reported late last year that nearly 15 million American workers may be exposed to substances known or suspected to cause birth defects, spontaneous abortions and other health hazards. Among the high-risk agents listed were ethylene glycols, used in solvents, antifreeze, aviation fuels, brake fluids, paints and paint thinners; anesthetic gases, common in hospital operating rooms; ethylene oxide; formaldehyde; inorganic lead; chloroprene; cadmium; and dibromochloropopane. In addition, some nine million workers are exposed to radio frequency-microwave radiation used for heating and drying in the automobile, textile, furniture, rubber and other industries, the NIOSH report said.

However, making definite links between potentially dangerous substances and certain medical conditions is a long and difficult process, involving long-range studies by scientists, medical experts and government investigators in attempts to uncover valid cause-effect relationships.

"What we can say is that there has been a definite shift from the occurrence of the traditional infectious and communicable diseases to chronic diseases in general," says John Sestito of the Cincinnati branch of the National Institute for Occupational Safety and Health. "In the same respect, there has been the development of a higher level of awareness regarding the importance of workplace factors in relation to disease effects."

Sestito goes on to point out that "the post World War II era saw a tremendous change in industry and technology," along with "a tremendous infusion of chemicals into the occupational environment." Parallel to all of this has been an increase in the incidences of cancer and radiation hazards," says Sestito. "But this could be a function of many things."

Determining exactly which chemicals, dusts or other hazardous materials cause which

illnesses or diseases is one of the many responsibilities of NIOSH. "Our division responds to requests from the workplace — either from employers or employees — regarding these hazards," Sestito explains. "We also support industry with broad-based studies of occupational hazards and their effects on health, and our investigators try to come up with cause-response links between hazards and diseases."

Yet the work environment changes so rapidly and the findings are so prolific that it takes constant study on the part of scientists, physicians and others in health care to put together these links.

Perhaps one of the best resources available to researchers — as well as physicians involved in caring for patients with the potential for worker-related diseases — is an article which appeared in the September 1983 issue of the *American Journal of Public Health.* The article contains a four-page bibliography with nearly 200 references to documents and studies which have linked occupational factors to illnesses and conditions, ranging from malignant neoplasms among coke oven steel workers to scrotal carcinoma in Connecticut metal workers.

The article is must-reading for any physician who treats patients involved in high-risk occupations, Sestito believes. "It is a comprehensive overview of literature which suggests relationships between certain hazards and certain illnesses," he explains. "Its purpose is to make the practicing physician more aware of these hazards."

According to the article, "successful control of occupationally related diseases depends on two factors: recognition and diagnosis of cases by physicians, and the implementation of surveillance, prevention and occupational control programs. Sadly, both of these factors have historically received inadequate attention."

Instead, the question of whether or not a certain illness or injury is the result of one's work has traditionally been a matter settled by the courts or — in Ohio — by the Industrial Commission, a five-member board appointed by the Governor which hears and decides all contested claims.

According to Lucid, anywhere from 15% to 20% of Workers' Compensation claims per year are contested. Cases in question first are reviewed at a district hearing in order to determine the validity and extent of the claim. From there, an employer or claimant may appeal the case to a regional board of review. If the case is still not settled to everyone's satisfaction, it then goes to the Industrial Commission itself, who may or may not decide to hear the appeal, based on the merits of the case.

"The question of whether or not an injury or illness is job-related is ultimately a legal one," says John Starr, MD, chief medical advisor to the Ohio Industrial Commission and the Bureau of Workers' Compensation. Physicians working both for the state and in private practice, however, often help to decide the issue. "The question may be referred to us to determine a cause-effect relationship from a medical standpoint," Dr. Starr explains. A medical section of 15 physicians works full time to help answer those questions, along with 200 to 600 consulting physicians statewide who assist the

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Hazards in the Workplace

continued



Commission in this capacity. "But 99% of the time, it's not an issue of industrial illness or injury, but the amount of the injury the patient has suffered," Dr. Starr adds, and whether or not he or she is permanently or partially disabled.

According to Dr. Starr, any physician who is taking care of a patient who may be suffering from a work-related condition should keep careful and detailed records of both symptoms and treatment. For reimbursement purposes, "it is important that a physician carefully explain both the history and the medical evidence," says Dr. Starr, who frequently reviews the questionable cases on paper, "along with any exam or tests results which would indicate a cause-effect relationship."

Any physician who *intentionally* misrepresents a case in order to help a patient to obtain Workers' Compensation coverage and benefits can be charged with fraud, Dr. Starr says. While this type of intentional deceit does not happen frequently, there are numerous instances where papers are filed with Workers' Compensation, yet there is no clear evidence linking the disorder being treated to a work-related incident. As an example, Dr. Starr points to a case where a worker received a blow to the back of his hand. Two years later, a tumor was removed from the palm of the hand and a claim was filed for removal of the tumor.

"It's not that we're questioning the physician's diagnosis or treatment," Dr. Starr explains. "Yet at the same time, it is not clearly indicated how the injury which occurred two years earlier was linked to the need for the surgery."

The best way to safeguard against such gaps in information is to keep ongoing records of the patient's condition and to regularly pass these along to the Workers' Compensation Bureau, says Dr. Starr. "That way, if surgery is required somewhere down the line, the link will be evident."

In other cases, a patient may lie to a physician about his or her condition in hopes of gaining Workers' Compensation benefits. In these cases, "we don't expect the physician to investigate either the worker's story or the workplace," Dr. Starr says. "Obviously, you have to take what the patient tells you at face value. However, if the evidence you are seeing does not correspond with what the patient is telling you, you are obliged to report that."

In those cases which are in question, compensation and reimbursement may be held up for months until all hearings are completed and a decision is reached. Delays in or denial of compensation is one reason why some physicians are hesitant to treat individuals who suffer from work-related injuries or illnesses.

The wait can be frustrating for both patient and physician, admits Yvonne Pompey, director of the Medical Cost Containment Section of the Bureau of Workers' Compensation, a new section formed last July to enhance communications between the bureau and the state's health care providers.

"The bureau, by its very nature, is a very complex system," Pompey admits. "Because it is a legal system, it is necessarily difficult."

However, efforts are currently being made to help physicians and other medical providers with

claims in order to speed up the process. For example, sometimes reimbursement is delayed when physicians file incomplete forms with the bureau, or when they fail to turn in the background information needed to decide the case.

It is for this reason that a new publication has been created called the *Health Care Communicator,* which is being mailed quarterly to some 50,000 medical providers in the state who have dealt with the Workers' Compensation System in the past. The newsletter, which is free of charge, contains the latest information on the policies and procedures of the Industrial Commission and the Workers' Compensation Bureau — along with an update on worker-related illnesses and diseases under study.

Any physician who has been reimbursed by the bureau in the past and has been assigned a Bureau of Workers' Compensation (BWC) industrial payee number will get the publication free of charge starting this month. A second resource which regularly goes to those same physicians is a 47-page booklet called *Guidelines for Health Care Providers* which summarizes what physicians need to know about the Workers' Compensation System, including how to file forms, reimbursement issues, medical authorizations and general procedures.

"We are trying to get a communications system going between the providers and the bureau," Pompey says. "We know we are different from anything else physicians have to deal with. Working with the bureau can be very cumbersome, and the providers get very frustrated. As a result, some claimants may suffer."

The division is also hoping to receive and answer questions from medical providers having problems with the system. They may write in their questions to the *Communicator,* or call a special telephone number that has been set up solely to answer their questions. These can range to anything from "Why haven't I been reimbursed?" to "Could this be an occupationally related disease?"

Since human beings first put their minds and hands to work, job-related injuries and illnesses have existed. Still, much remains unknown about those elusive conditions and diseases that may result from long-term, day-to-day exposure to the vast array of substances now used in business and industry.

Recognizing and treating these less-apparent yet potentially serious conditions is as much a challenge to today's physician as is reattaching a severed limb or restoring the use of an injured muscle. What's more, it will take the concerted effort of researchers, physicians and scientists throughout the state and country, along with leaders in labor, management and government to truly make Ohio and the U.S. work environment more healthful and hazard free. **OSMA**

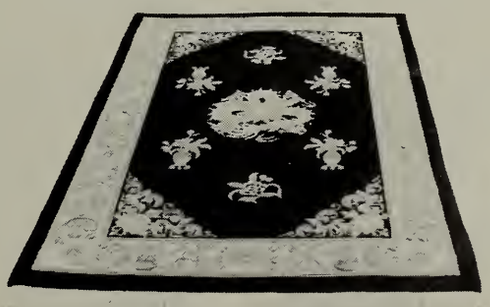
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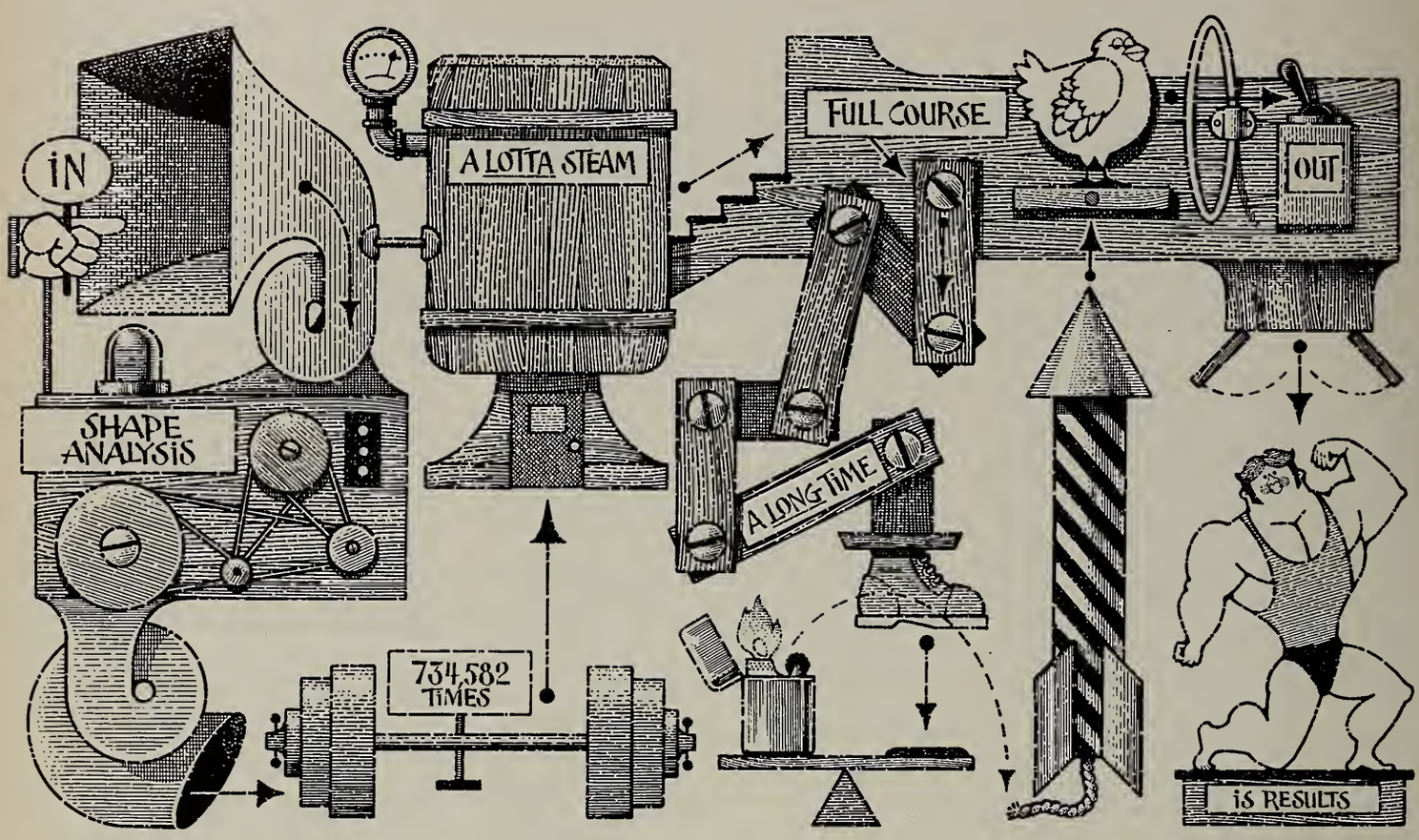
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Business Body Shops

How corporate fitness centers are shaping America . . .

By Karen S. Edwards

In Charles Dickens's day, work places were often called "sweat shops" — an honest, if not flattering name for the type of morning-till-night labor expected of the Victorian employee.

Today's typical office worker, however, has little reason to sweat. Technology continues to update and improve the work place so that, anymore, fewer and fewer collars — white *or* blue — are being dampened by the kind of good, honest sweat that Dickens and his contemporaries experienced firsthand.

Perhaps in reaction to this large, sedentary chunk of the day, workers all over America (and who isn't a worker these days?) began to embrace the fitness concept — the jogging-racquetball-aerobic dance craze that is populating our streets with hundreds of colorful bouncing figures and our spas with an equal number of would-be Jane Fondas.

Only time prevented the fitness trend from entering the work place itself, and in the last several years, that time has run out, as employers (the customary fitness trend-setters), realizing how their own sense of well-being has paid off at work, are now showing an increased willingness to pick up the cost of keeping their employees physically fit — or getting them that way if they aren't already. As a result, corporate fitness centers are springing up all over the state.

"Companies today are sold on the benefits of exercise and wellness," says Steve Grill, the Metropolitan Director of Corporate Fitness Centers for the YMCA, Columbus. "Corporate fitness centers give employees a place to go where they can exercise regularly."

But not just *a* place to go. The options now available to the fitness-minded employer are mind-boggling.

There are, for example, the on-site centers, such as the six which Grill directs in Columbus. These centers are actually on company premises, and range from Worthington Industries' comprehensive field-house complex, complete with 1/16-mile jogging track and basketball/volleyball courts with computerized score boards to more humble centers which offer basic equipment in a minimal amount of space.

Nationwide Insurance Company, with its basement facility, is a typical example.

"Nationwide was one of the first companies to develop a corporate fitness center," Grill explains. "They saw the potential of these centers and went with it — before fitness was ever a trend."

Nationwide, in fact, opened its first fitness facility in 1964. Public relations employee Bob Sayre remembers it well:

"We were in the old building then, and a corner of a stockroom had been cleared for some weights, a stationary cycle and a rowing machine."

The locker room facilities were so limited that women were restricted from using them on Mondays, Wednesdays and Fridays; and men had to stay away Tuesdays and Thursdays.

"The weekends depended on who got there first and locked the door against the others," Sayre says with a laugh.

Companies today are sold on the benefits of exercise and wellness . . . and corporate fitness centers allow employees to exercise regularly.

But with Nationwide's move into a brand-new building, the fitness center was given its own space — about 3500 square feet, with a 2300 square foot annex for fitness and aerobic dance classes. The workout room itself is L-shaped and brightened with highly polished mirrors. There are weights, running machines and enough chrome-plated Nautilus equipment to make Hulk Hogan long for a business suit. In fact, when power-man Arnold Schwarzenegger is in town, he drops by the facility to keep his muscles in shape.

According to Grill, however, Nationwide employees are the only ones customarily permitted to use the facility. Even families of employees are off-limits because of liability considerations.

But that might be just as well. The company estimates that nearly 1000 employees now use the center, and even though the room is open 24 hours a day, seven days a week, Sayre admits that the center can get crowded during peak periods like the lunch hour and before and after work. Since the center is co-educational, men and women exercise together — from the young, to the middle-aged and up.

"The average age of participants is about 36," Grill says, although ages range from 18 or 19 up to retirement age.

At 62, Sayre falls into the latter category — but he is certainly every employer's idea of a health-conscious employee. Although a muscle injury has caused Sayre to give up his place in the workroom, he continues to keep himself physically fit with a 3-to-4 times a week jogging routine.

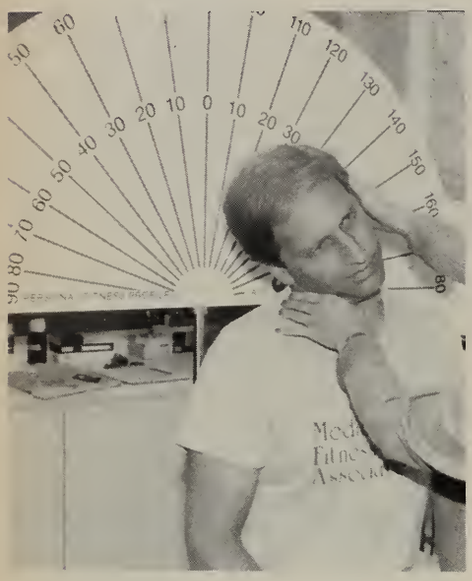
"Now," Sayre says, "going without exercise is like going without a shave. I know I'll live through it, but I feel guilty if I don't do it."

Guilt — or an increased health awareness made possible by the fitness center — has caused Sayre to make other lifestyle changes as well. In 1968, for example, he gave up smoking — four years after he started his fitness program at Nationwide, and he says he is now more conscious of what he eats.

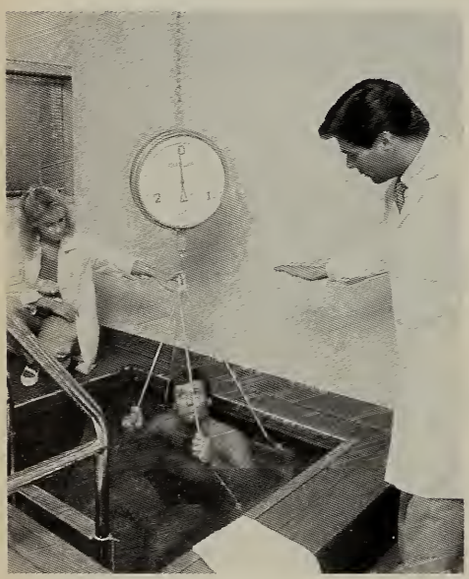
In case he isn't, Nationwide *does* keep a nutritionist on duty in the medical department to offer advice, but the fitness center is not

Business Body Shops

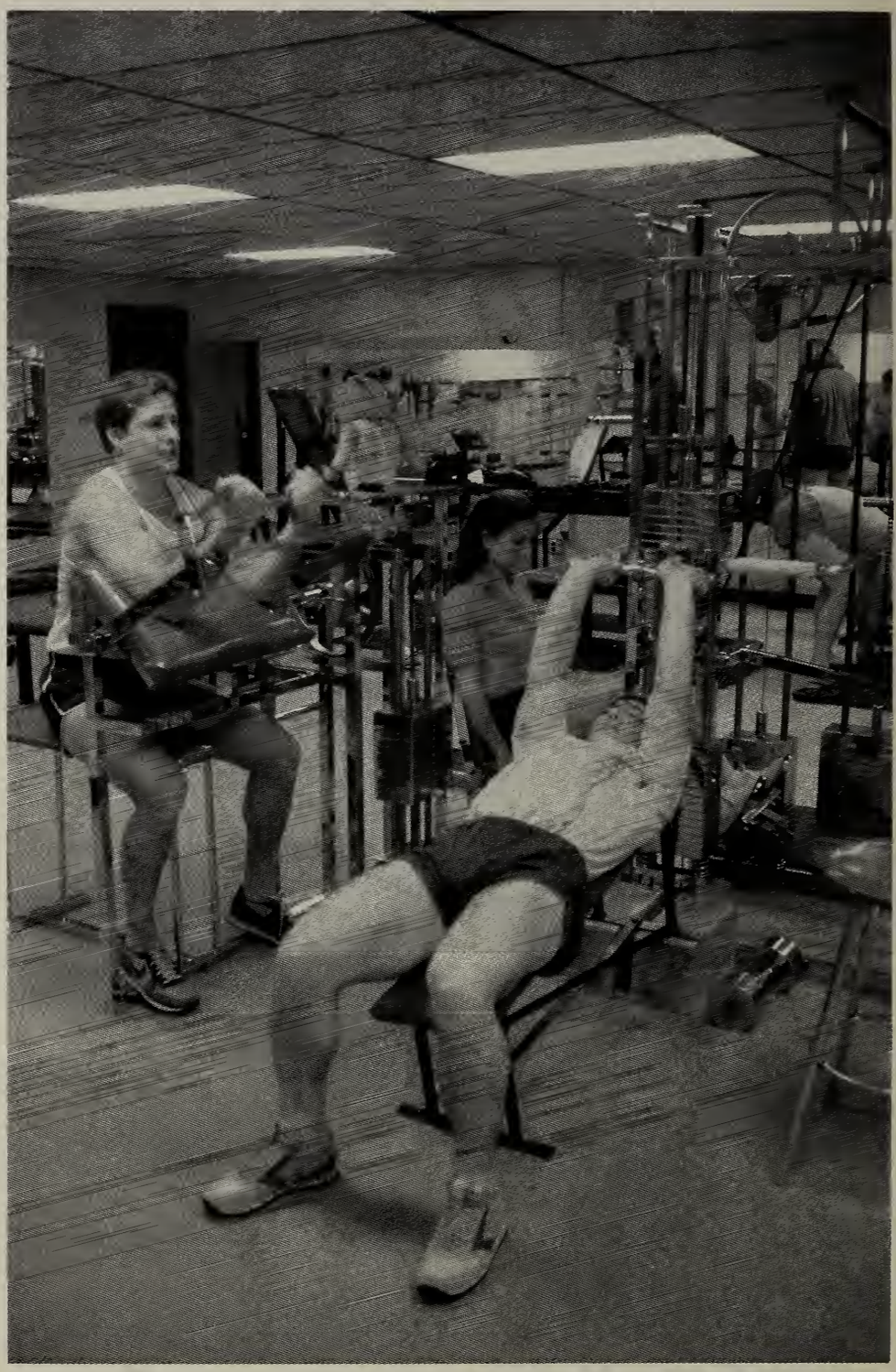
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Dr. Kirschner's Medical Fitness Associates offers personal fitness profiles (photo courtesy of Medical Fitness Associates).



St. Vincent's underwater weighing tank provides an accurate measurement of fat to muscle (photo courtesy of St. Vincent's Charity Hospital).



Nationwide Insurance employees make time to use the company's well-equipped corporate fitness center (photo by Tom Brunk, courtesy of Nationwide).

under that section's control. Instead, it falls under the auspices of the company's services and activities department — and the YMCA.

The Y staffs the center for 10 hours each day, and, like the other facilities it directs, it offers center participants a health-screening check and a fitness evaluation.

"The fitness evaluation is nothing too complex or clinical," says Grill. A resting heart and blood pressure rate are taken, body fat is measured, and various fitness and flexibility tests are given.

The results are tabulated manually and through a computer.

"We determine what level of fitness they're at, and we go from there," says Grill.

Areas of weakness are pointed out to participants, but Grill quickly explains that participants choose their *own* fitness programs.

"For example," he says, "a man who lifts weights can measure very high in strength, but weak in aerobics. We tell him that being strong is just one aspect of fitness — that aerobic strength is important, too. But we ask him what *he* wants to do to get physically fit. We just hope he takes the information we've passed on to him and includes some aerobic activity in his training."

If he does, the Y is there to offer suggestions on how best to accomplish those goals.

But what of those companies where space, or maybe the number of employees, makes an on-site facility impossible?

According to studies conducted by the YMCA, there are proportionately few companies in the state where on-site corporate fitness centers *are* possible. Columbus, with its recent spurt in economic growth and development, leads the rest of the state in on-site centers — largely because of the number of new buildings being built by companies which plan early to include a space for employee fitness.

"When the American Electric Power Company was being built, AEP executives visited Nationwide's fitness center and said, 'This is what we want,' " says Grill.

Those companies confined to their own small quarters, however, needn't despair. Fitness services for employees complete with off-site fitness centers are being marketed all over the state, by a variety of sources.

There are proportionately few companies in the state where on-site corporate fitness centers are possible.

Hospitals, for example, have been quick to enter this new occupational fitness arena. St. Vincent Charity Hospital and Health Center in Cleveland, for example, opened its doors to a new Occupational Health and Wellness Center this past May.

"In addition to the traditional occupational medicine programs, like executive physicals and health screening, we also offer the employer a variety of services which emphasize wellness," says Susanna Krey, Division Director of Health Promotion at St. Vincent's.

In fact, the hospital's wellness programs are also open to anyone in the community interested in health promotion, and classes are usually a good mix of business executives and consumers, says Krey, adding that the hospital's "Excel" program teaches nutrition and weight control by providing participants with personal fitness profiles, much like those Nationwide employees receive from the YMCA, but on a more sophisticated basis. A physical exam at St. Vincent's includes an EKG stress test, for example, and body composition (fat to muscle) can be determined by an underwater weighing tank, which, according to Krey, provides a more accurate picture than other means of measuring.

"A person can be overweight but not fat," explains Krey, adding "a Cleveland Browns player is a perfect example" of why careful measurements need to be taken.

Metabolic tests are also given to decide what caloric level is best suited to the individual.

Once testing is complete, personalized fitness routines are designed, and participants are encouraged to attend 12-week "lifestyle" management classes which teach anger and body image control among other subjects.

Unlike the on-site center at Nationwide which, according to Sayre, reaches largely middle-management levels and below, St. Vincent's is seeing the cream of the executive level.

"You can tell the caliber of our clientele by the requests they're making," she says. For example, the center now offers Walkman radios with a selection of professional tapes for those who want to do press-ups while Lee

Business Body Shops

continued

Iaccoca urges them to strive for excellence. And a cable TV will soon be installed so morning exercisers won't have to miss the news.

The hospital also offers a stress management program, and although nutrition and exercise are considerations here, too, the subjects take on a slightly different focus in this program.

"The exercises are more likely to be relaxation exercises than aerobic, and nutrition counseling concentrates more on what a healthy diet *is* than how to count calories," Krey explains.

Participants in the center's programs need not go far for their first nutrition lesson, either.

A new Wendy's restaurant is on the premises — the first Wendy's in the country to be housed in a medical complex.

Krey and several of the center's dieticians have made sure, however, that the meals offered here are even more nutritious than those offered at other off-premise restaurants.

"We made a trip to Wendy's international headquarters in Columbus and explained what we wanted," she says.

As a result, Wendy's customers will find more fruit — and different salad bar ingredients — on the center's menu.

"We also provide the customers with nutritional and caloric information so they can make wise food selections," she adds.

Thirty companies have already contracted St. Vincent's services, and Krey says at least that many more are considering proposals. In addition, 130 companies are using the hospital's emergency room services, as well as its more traditional occupational health services, such as disability screening, rehabilitation and alcohol and drug counseling.

"We've had a lot of positive feedback from the employers and employees who have contracted with us," says Krey.

One executive recently told her that after six months of fitness training, he thought his mental capacity had increased 25 percent, and now, he had the energy to continue working all day . . . "if I wished to do so," he was quick to add.

One person who *does* work all day — or at least seems to — is Jack Kirschner, MD, of Cincinnati — but with good reason.

A year ago, Dr. Kirschner started his own company, Medical Fitness Associates, which markets fitness services to area businesses.

"We're trying to reach the decision makers first," but he acknowledges there is a wide market out there for other workers.

"Thirteen or fourteen years ago, I thought the time was right to start a corporate wellness program," says Dr. Kirschner. A cardiologist who has long been involved with cardiac rehabilitation, he thought companies would jump at a preventive medicine program for their employees.

He was wrong. At the time, no one was interested, he says. Then, six or seven years ago, the times finally caught up with him. Fitness became trendy, and company executives began jogging to work.

"Unfortunately, the interest rate six or seven years ago was 21 percent, so I just couldn't get a business off the ground." But it didn't stop him from making plans for the day interest rates would fall.

"I looked around the country to figure out what it was I wanted to do," he recalls, and his contacts with the American College of Sports Medicine led him to fitness-aerobics expert Kenneth Cooper. He was offered a position at one of Cooper's prestigious clinics.

"But I decided I didn't want to work at a spa," he says.

What Dr. Kirschner *did* want to do was open a freestanding fitness center in the Blue Ash area, a Cincinnati suburb with a number of small, white-collar businesses — the kind of markets Dr. Kirschner thought would be perfect for Medical Fitness Associates. He opened for business last year, and he says he is still targeting as his markets the smaller companies who can't afford or don't have room for an on-site, corporate fitness center.

Like St. Vincent's, Medical Fitness Associates is drawing largely executive personnel, but Dr. Kirschner says that, right now, these are the clients he is trying to attract.

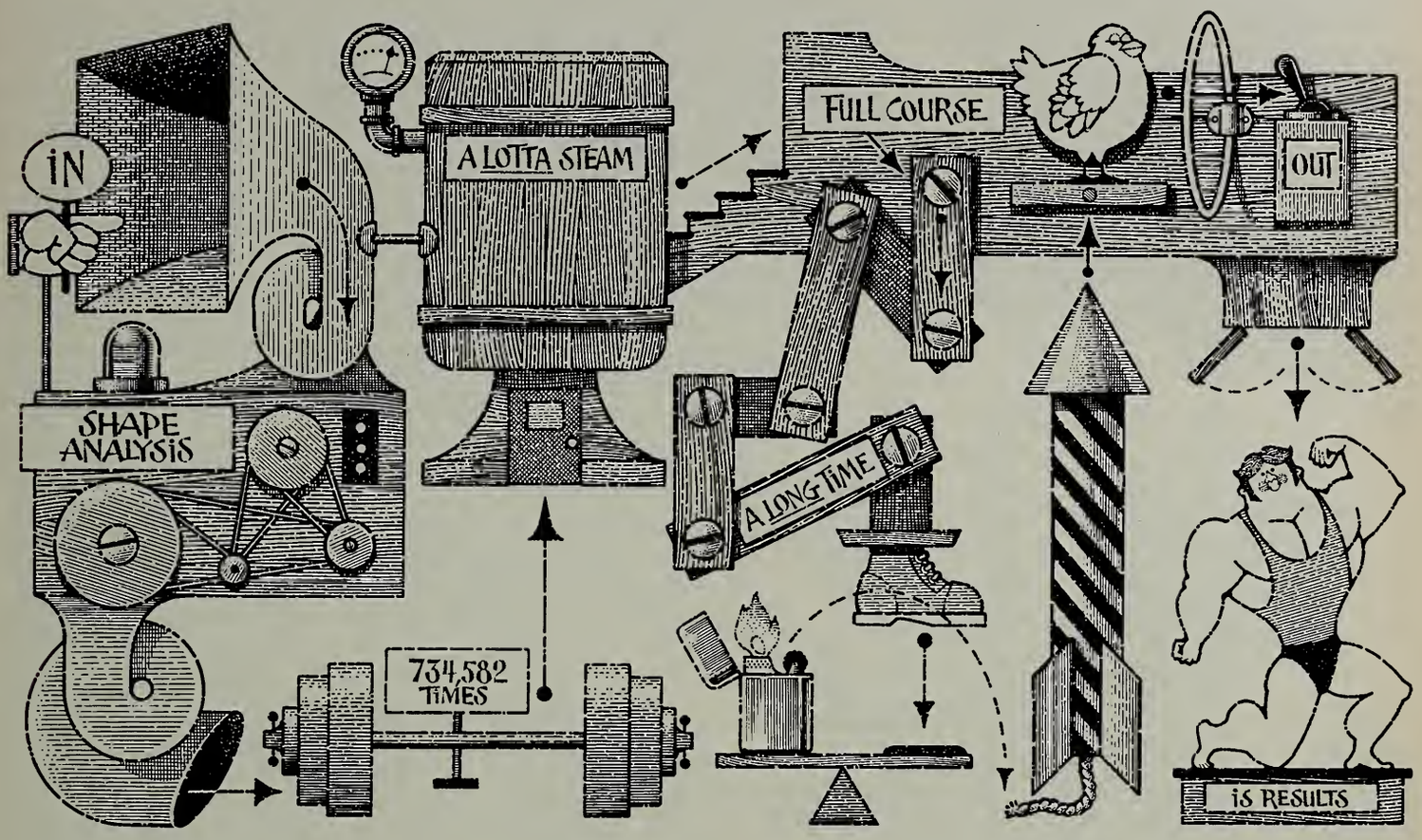
"We're trying to reach the decision makers first," he says, but he acknowledges there is a wide market out there for other workers as well, especially in terms of education.

Right now, Medical Fitness Associates is offering clients much that is being offered through Nationwide and St. Vincent's — personalized fitness profiles, nutrition programs, and perhaps the most complete physical exam offered anywhere.

"We offer approximately eight programs, and the company can select what it wants according to its needs," says Dr. Kirschner.

He tries to keep his programs preventive in nature, steering away from the traditional treatment side of occupational medicine.

"It's very difficult for a doctor



to be involved in both worlds. I know, I'm doing it," Dr. Kirschner says, referring to the fact that he continues to keep his cardiology practice in Cincinnati, in addition to his new business.

"You develop a schizophrenic attitude. When a patient walks into my practice, I have to take a look at the problem he has *now,* and attack it from that level. At the center, we look at what is left, and how we can modify the patient's lifestyle to make his life longer or better."

And that seems to be where *public* interest lies — in longer, healthier lives.

But most agree that *other* motives have driven *business* into the wellness marketplace.

"The spiraling costs of health care has a lot to do with why these fitness centers are growing so fast," says the YMCA's Grill. "Although in marketing our fitness programs (the Y also markets off-site fitness programs, and claims they already have one-half the market share in this area), we've never approached a company from this bottom line cost-saving angle. But make no mistake — these companies are aware of how health care costs are escalating and how fitness can result in lower stress levels and better work attitudes — and in fewer absentee days for their employees."

Companies are aware of how health care costs are escalating and how fitness can result in lower stress levels.

They know, too, that if you take Joe, who is 50 years old, overweight, and a smoker, and you can clean up his act, you can reduce the costs of the health care that would have to be spent if Joe *didn't* shape up his act, Grill explains.

How much is shaping up an act likely to cost an employer? That depends on the type of program the employer selects.

Nationwide, for example, offers its fitness center to employees for $50 a year, plus the $2 it costs to join the company's service and activities department. Once a member, participants can sign up for various seven-week courses for $15. A 20 percent corporate discount is also extended to those who wish to become members of the YMCA itself — so they can take advantage of the Y's more comprehensive facilities. A first-year membership at the Y costs $182 and entitles the new employee-member to free use of both the Y and Nationwide's fitness facilities, as well as a reduction in course rates.

"We provide a pyramid of levels which rewards those participants who become more



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HARMARVILLE

Business Body Shops

continued

active in fitness programs," says Grill.

While there are no pyramids at St. Vincent's, there *are* selections to be made from a smorgasbord of fitness programs — and prices can be high or low, depending on what those selections are.

For $25 a person, an employer can buy a health-risk appraisal, as well as some of the wellness programs offered by the center. The more complex the programs or extensive the tests, the higher the price — meaning anywhere from $200 to $600 per person, says Krey.

Medical Fitness Associates offers what Dr. Kirschner describes as the "best buy in town" — a life-style evaluation, various fitness tests, a print-out of results and a personalized fitness routine — all for $325. The complete physical, mentioned earlier, is available at an additional "small cost."

So, wellness is not exactly *inexpensive* either, but, as Dr. Kirschner puts it:

"If preventive medicine didn't make good financial sense, these companies wouldn't be doing it."

But doing it they are, and Krey thinks the time has come for preventive medicine in the work place.

"It's come and gone on several different occasions, but this time, I think it's here to stay. And I think companies are doing a lot more than paying lip service to the idea."

Dr. Kirschner agrees.

"Preventive medicine is the way things are going. I think it's the future of medicine," he says — a future which he sees taking a much more multi-disciplinary approach.

In fact, all three of the corporate fitness programs mentioned here are proud of their multi-disciplinary teams — which include nutritionists, nurses, psychologists, therapists and exercise specialists.

"I think it shows that it is not just the physician who should be involved in these programs," Dr. Kirschner says.

In fact, the most important person involved in any of these programs is the individual, says Grill.

The YMCA is concerned, maybe more than most, about those it calls its "fitness dropouts" — those who begin at the center and then, for some reason or other, drop out.

Grill says that dropouts need continuous consultation and encouragement.

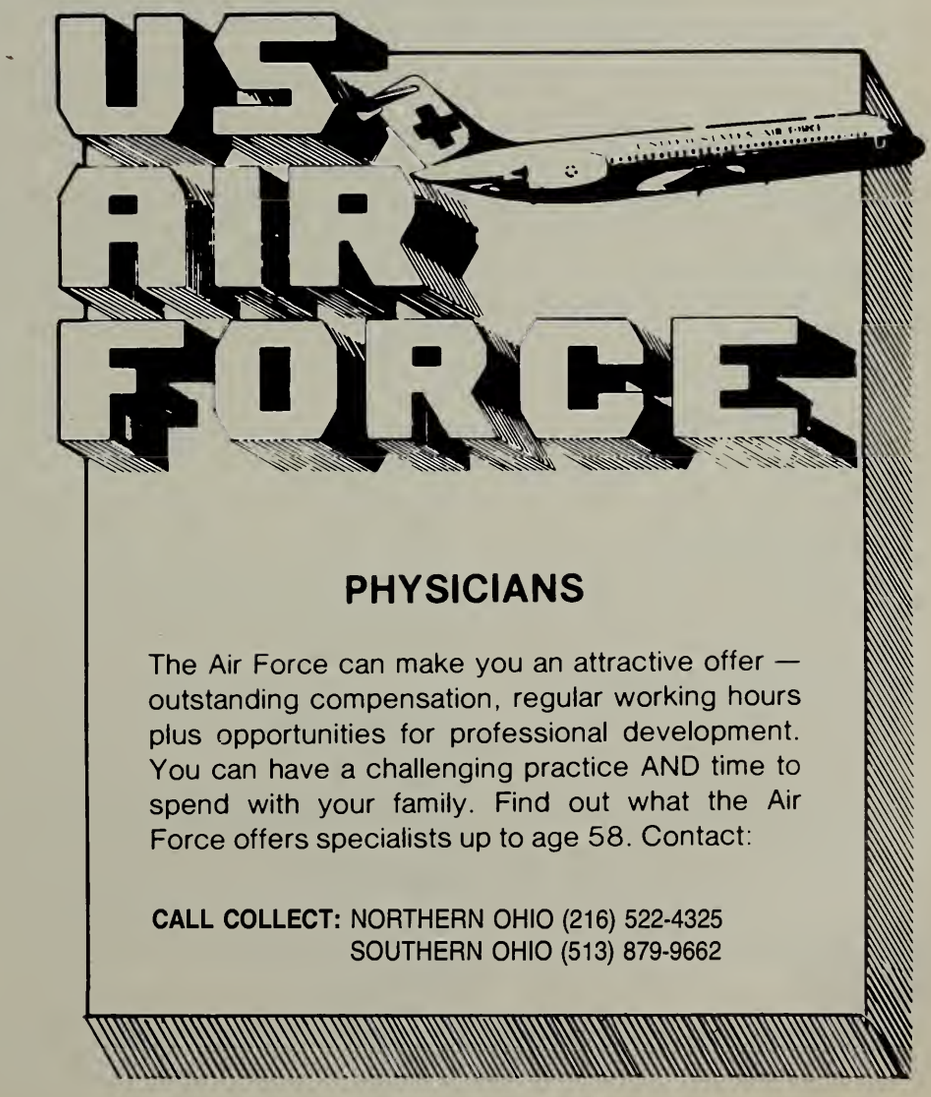
"We call them to ask how they're coming along, and send them cards when we haven't seen them at the center for awhile — just to find out why they haven't come. If there is a problem, we want to know about it," he says.

But no matter what the experts do to cajole the dropouts — and no matter what kind of programs corporations buy . . . or how much they spend on their employee fitness programs, fitness *is*, ultimately, the individual's responsibility.

"You can't hold hands in this business," says Grill. "You can't physically walk each employee down to the facility and make them exercise. It's up to the individual to be responsible for his or her own exercise program."

And even in the *best* business body shops, say the experts, that's the way it shapes up. **OSMA**

Karen S. Edwards is the Executive Editor of the **Ohio State Medical Journal.**



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1986 BUDGET

Total Revenue	$3,904,765.00
Expenses:	
Salaries & Emp. Benefits	$1,931,225.35
Travel & Mtg. Costs	196,900.00
Leadership Costs	131,000.00
Annual Meeting	191,000.00
Professional Relations	18,515.00
Membership & Fed. Relations	147,785.00
Communications	195,600.00
Government Relations	3,500.00
Representation	19,250.00
Education	24,650.00
Professional Fees	126,000.00
Publication Costs	227,100.00
Other Operating Expenses	494,580.00
Capital Accounts	101,950.00
Contingency Funds	38,750.00
Total Expenses	$3,847,805.35
Projected Excess Revenue	$ 56,959.65

REPORT OF INDEPENDENT ACCOUNTANTS

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the balance sheets of Ohio State Medical Association at December 31, 1984 and 1983 and the related statements of operations and undesignated net worth and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. We did not examine the financial statements of Physicians Administrative Corporation of Ohio, a wholly-owned subsidiary, for the year ended December 31, 1984 which financial statements reflect total assets of $714,478 and total shareholder's deficit of $165,159. These statements were examined by other auditors whose report thereon has been furnished to us and expresses a qualified opinion. Our opinion expressed herein, insofar as it relates to the amounts included for Physicians Administrative Corporation of Ohio, is based solely upon the report of other auditors.

As described in Note 7, the opinion expressed by the other auditors on Physicians Administrative Corporation of Ohio (PACO) was qualified because of uncertainties as to the collectibility of a note receivable, and as to the ability of PACO to continue in existence. The financial statements of PACO do not include any adjustments relating to the recoverability and classification of recorded assets or the classification of liabilities that might be necessary should PACO be unable to collect its note receivable or continue in existence. At December 31, 1984, the Ohio State Medical Association had guaranteed or made commitments to guarantee bank borrowings of PACO totaling $300,000. Should PACO be unable to continue in existence and sell the rights to its proprietary software as described in Note 12, the Ohio State Medical Association might be required to repay bank borrowings on behalf of PACO.

In our opinion, based upon our examination and the report of other auditors, and subject to the effect on the financial statements for the year ended December 31, 1984 of such adjustments, if any, as might have been required had the outcome of the uncertainty referred to in the preceding paragraph been known, the financial statements referred to above present fairly the financial position of the Ohio State Medical Association at December 31, 1984 and 1983 and the results of its operations and changes in its financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Coopers & Lybrand

Columbus, Ohio
July 16, 1985, except as
to Note 12, which date
is November 6, 1985

OHIO STATE MEDICAL ASSOCIATION

BALANCE SHEET

December 31, 1984 and 1983

ASSETS	*1984*	*1983*
Current assets:		
Cash and cash equivalents	$ 931,082	$2,462,206
Accounts receivable	77,096	84,346
Accounts receivable, PICO	3,900	56,246
Accounts receivable, PACO		62,604
Prepaid expenses	52,762	49,693
Total current assets	1,064,840	2,715,095
Other assets:		
Funds restricted for designated purposes (Note 2)	542,276	512,511
Notes receivable:		
Mortgage (Note 5)	59,342	59,342
Other	84,700	111,494
Investments:		
General Trust Fund, (net of amount owed to pension plan, $46,276 in 1983), approximates market	87,722	71,328
Physicians Insurance Company of Ohio (PICO), at cost (Notes 3, 4, and 9)	100,000	100,000
PRORECO Reinsurance Corporation, Ltd. (PRORECO), at cost	25,000	25,000
622 South High Street, Inc. (Note 5)	24,397	24,989
Physicians Administrative Corporation of Ohio (PACO) (Note 6)		68,792
Real estate (building — $2,090,000; equipment — $260,000; net of accumulated depreciation of $195,625 in 1984 and $117,375 in 1983) (Note 9)	2,154,375	2,232,625
IONA, Inc., at cost	25,000	
	3,102,812	3,206,081
Property and equipment, at cost (Notes 1 and 8):		
Building	572,481	572,481
Data processing equipment	200,619	274,450
Furniture, fixtures and equipment	156,153	153,137
	929,253	1,000,068
Less accumulated depreciation	(361,078)	(382,830)
	568,175	617,238
Land	448,628	447,717
	1,016,803	1,064,955
	$5,184,455	$6,986,131

The accompanying notes are an integral part of the financial statements.

LIABILITIES AND NET WORTH	*1984*	*1983*
Current liabilities:		
Accounts payable	$ 235,956	$ 208,271
Accounts payable, PICO (Note 3)	5,478	1,502,045
Current portion, term debt (Note 8)	14,692	27,542
Other current liabilities	293,651	282,046
Total current liabilities	549,777	2,019,904
Term debt (Note 8)	2,472,230	2,486,156
Deferred income:		
Annual membership dues (Note 1)	498,195	379,219
Life membership dues (Note 1)	31,100	33,150
Other	64,587	76,670
	593,882	489,039
Commitments and contingencies (Notes 6 and 7)		
Net worth (Note 2):		
Designated funds	542,276	512,511
Undesignated funds	1,026,290	1,478,521
	1,568,566	1,991,032
	$5,184,455	$6,986,131

The accompanying notes are an integral part of the financial statements.

STATEMENT OF OPERATIONS AND UNDESIGNATED NET WORTH
for the years ended December 31, 1984 and 1983

	1984	*1983*
Income:		
Membership dues (Notes 1, 3 and 11)	$2,255,071	$2,216,526
Exhibit fees	7,276	5,400
Annual meeting	13,163	3,370
Fees for collection of AMA dues	12,306	16,399
CME accreditation and courses	6,173	3,875
Ohio State Medical Journal (Note 11)	184,805	206,808
Interest	268,938	239,881
General trust income	20,961	8,666
Administration and technical service (Note 3)	70,000	70,000
Rental income	21,788	19,738
Promotion and development (Note 3)	172,828	164,486
Services to specialty societies	69,187	32,862
Other	109,247	112,940
	3,211,743	3,100,951
Departmental operating expenses:		
Administration	568,929	514,679

Education, specialty societies and meeting management	527,119	448,020
Health education	118,451	109,171
Field service	109,880	130,337
Fiscal and membership	430,066	375,400
Government relations	181,609	133,735
Communications	626,436	628,339
Development and member services	286,455	280,524
State legislation	208,979	206,691
Legal services	185,925	199,097
	3,243,849	3,025,993
Income (loss) from operations before loss from lease to related party and equity in losses of subsidiaries	(32,106)	74,958
Loss from lease to related party (Note 9)	(51,724)	(51,589)
Equity in losses of subsidiaries and loss on advances to PACO (Notes 5, 6 and 7)	(338,636)	(145,117)
Net loss from operations for the year	(422,466)	(121,748)
Undesignated net worth, beginning of year	1,478,521	1,691,097
Transfer to designated funds, net (Note 2)	(29,765)	(90,828)
Undesignated net worth, end of year	$1,026,290	$1,478,521

The accompanying notes are an integral part of the financial statements.

STATEMENT OF CHANGES IN FINANCIAL POSITION
for the years ended December 31, 1984 and 1983

	1984	*1983*
Cash provided from (used for) current operations:		
Net loss	$(422,466)	$(121,748)
Add charges not involving cash:		
Depreciation and amortization	142,189	165,360
Equity in losses of subsidiaries and loss on advances to PACO	338,636	145,117
	58,359	188,729
Decrease in accounts receivable	59,596	77,911
Increase in prepaid expenses	(3,069)	(4,224)
Increase (decrease) in accounts payable	(1,468,882)	306,966
Increase in other current liabilities	11,605	6,456
Increase in deferred income	104,843	38,559
Cash provided from (used for) current operations	(1,237,548)	614,397
Cash provided from (used for) financing activities:		
Decrease in current portion, term debt	(12,850)	(28,424)
Repayment of term debt, net of conversions to current portion	(13,926)	(26,398)
Cash provided from (used for) financing activities	(26,776)	(54,822)
Cash provided from (used for) investment activities:		
Increase in funds restricted for designated purposes	(29,765)	(90,828)
Increase in General Trust Fund	(16,394)	(8,666)
(Increase) decrease in notes receivable	26,794	(71,897)
Investment in 622 South High Street, Inc.		(6,800)
Investment in PACO		(85,000)
Amounts advanced to PACO	(206,648)	(41,506)
Investment in IONA, Inc.	(25,000)	
Additions to property and equipment, net	(15,787)	(14,290)
Cash used for investment activities	(266,800)	(318,987)
Increase (decrease) in cash and cash equivalents	(1,531,124)	240,588
Cash and cash equivalents:		
Beginning of year	2,462,206	2,221,618
End of year	$ 931,082	$ 2,462,206

The accompanying notes are an integral part of the financial statements.

NOTES TO THE FINANCIAL STATEMENTS

1. *Accounting Policies:*
The following is a summary of certain significant accounting policies followed in the preparation of the financial statements. The policies conform to generally accepted accounting principles and have been consistently applied.
   a. *Depreciation:*
   The Association recognizes depreciation and amortization on the straight-line method in amounts adequate to amortize costs over the estimated useful lives of the assets as follows:
   Building and improvements ..... 10-40 years
   Data processing equipment ..... 5 years
   Furniture, fixtures and equipment ..... 10 years
   Depreciation and amortization charged to operations were $142,189 in 1984 and $165,360 in 1983. Disposals of fixed assets are accounted for as reductions to cost and accumulated depreciation. Any resulting gain or loss is credited or charged to other income.
   b. *Deferred Membership Dues:*
   Income from annual membership dues is recognized in the calendar year to which the dues apply. Life membership dues income is recognized over an estimated 25 years of active practice of the life membership participants.
   c. *Exemption — Federal Taxes on Income:*
   The Ohio State Medical Association is exempt from federal taxes on income under Section 501(c)(6) of the Internal Revenue Code.

2. *Funds Restricted for Designated Purposes:*
During 1984 and 1983, the Council of the Ohio State Medical Association authorized funds to be restricted for designated purposes. The funds represent cash and cash equivalents that have been designated for the following purposes as of December 31:

Balance sheet, 1984 and 1983

continued

	1984	*1983*
Capital Asset Improvements and Replacement	$139,428	$127,127
Data Processing Improvements and Replacement	258,255	202,186
Malpractice Research ...	56,090	54,944
Staff Development.....	88,503	128,254
	$542,276	$512,511

3. *Physicians Insurance Company of Ohio:*
The Association owns 100% of the Class B common stock of Physicians Insurance Company of Ohio (PICO). PICO has two classes of common stock, Class A and Class B. Each class of stock has equal rights on a per share basis to participate in dividends and other types of distributions. The Association earned $7,800 of dividend income in 1984 and $5,700 in 1983, which is included in other income in the accompanying financial statements. Each Class A share is entitled to one vote, and each Class B share is entitled to 100 votes.

By virtue of its ownership of 100% of the outstanding Class B shares (30,000 shares), the Association is entitled to 3,000,000 votes. At December 31, 1984, the Class A shareholders owned 2,560,553 shares of Class A stock. Accordingly, at December 31, 1984, the Association was entitled to exercise 53.95% of the voting power of PICO. If the total authorized Class A shares (8,000,000) and Class B shares (66,668) were to be sold, the Class A shareholders would hold approximately 55% of the voting control over PICO.

The Association has recorded its investment in PICO at cost instead of under the equity method since, although they own a controlling interest in PICO, they do not share significantly in PICO's earnings.

PICO is limited to selling medical liability insurance only to members of the Association. While medical students and residents do not currently need medical liability insurance, PICO wishes to encourage them to join the Association, hopefully leading to future insurance business for PICO. The Association and PICO entered an agreement whereby PICO agreed to reimburse the Association for direct and indirect costs of promoting organized medicine, including the promotion and servicing of new student and resident memberships in the Association. Total reimbursement for the national, state and county medical society membership dues of medical students and residents was $267,655 in 1984 and $235,514 in 1983. The portion of such reimbursements relating to OSMA's annual dues was $81,040 and $75,840 in 1984 and 1983, respectively, and is included in the membership dues income classification in the Statement of Operations. The Association received $132,345 in 1984 and $164,486 in 1983 as reimbursement for costs incurred in promoting and servicing the student and resident memberships. These amounts are classified as promotion and development income in the Statement of Operations.

In connection with a group professional liability insurance plan, OSMA receives premium payments from its member physicians for the PICO-insured coverage. The Association maintains these premiums on deposit monthly and, by agreement, remits such premiums to PICO on the fifteenth day of the following month.

PICO paid the OSMA $70,000 in 1984 and 1983, to defray other clerical and administrative expenses incurred by the Association on behalf of PICO. These funds are classified as administrative and technical service income in the Statement of Operations.

In recognition of OSMA's efforts in assisting PICO to secure an extraordinary assumption agreement, on December 13, 1983 PICO assigned to the OSMA a portion of amounts returnable to PICO under a separate, but related, agreement. In early 1984, this assignment was determined to have a probable ultimate value of approximately $2,200,000, with payments commencing in 1987 and ending in 1992. Since the ultimate receipt of such payments is not assured, no income has been recorded.

4. *Insurance Holding Company System:*
The insurance holding company system presently consists of two affiliated persons, the Ohio State Medical Association (OSMA) and Physicians Insurance Company of Ohio (PICO).

OSMA controls PICO by virtue of its ownership of 30,000 shares of Class B common stock of PICO, comprising 100% of such outstanding shares of stock (see Note 3).

5. *Investment in 622 South High Street, Inc.:*
During 1981, OSMA formed a corporation known as 622 South High Street, Inc. (622), having as its main purpose the ownership and management of property at 622 South High Street, Columbus, Ohio. In exchange for property which at December 31, 1980 had a book value of $85,000, the Association received 100% ownership in said corporation (100 shares of common stock at $255 a share) for $25,500 and a 10% mortgage note receivable for $59,500, maturing in 2029, payable in equal monthly installments of $500. During 1983, the building at 622 South High Street was demolished to make way for future expansion, ending 622's receipt of rental income and ability to pay mortgage payments to the Association. A payment made by OSMA of $6,800 for demolition work was accounted for as an additional investment. At December 31, 1984 and 1983, the note receivable had a book value of $59,342.

OSMA accounts for the investment using the equity method, and the investment account reflects the following activity for the years ended December 31:

	1984	*1983*
Investment in 622 South High Street, Inc., beginning of year	$24,989	$21,619
Additional investment .		6,800
Net loss	(592)	(3,430)
Investment in 622 South High Street, Inc., end of year	$24,397	$24,989

Condensed financial information for 622 South High Street, Inc. is as follows:

Condensed Balance Sheet

	December 31	
	1984	*1983*
Assets	$85,589	$86,181
Liabilities	61,192	61,192
Net worth	$24,397	$24,989

Condensed Statement of Operations

	Years ended December 31,	
	1984	*1983*
Rental income		$ 6,000

Expenses	$ 592	9,430
Net loss	$ 592	$ 3,430

6. *Investment in Physicians Administrative Corporation of Ohio:*
During 1982, OSMA formed a corporation known as Physicians Administrative Corporation of Ohio (PACO) whose main purpose is to sell computer systems and the related software to physicians for use in their practices and to provide services to physicians relating to processing third party billings. The Association owns 100% of the corporation and initially funded the Company with capitalization of $200,000 and software which had a book value of $15,000. In 1983, OSMA completed their commitment to capitalize PACO with an additional investment of $85,000. In addition, the Association has guaranteed a line of credit for PACO of $300,000. (See Note 7). On December 31, 1984, PACO signed a note payable to OSMA in the amount of $269,252, due March 31, 1985, with interest at 10%. The note can be extended by OSMA at any time and can be accelerated in the event of default.

OSMA accounts for the investment using the equity method. The investment account reflects the following activity during the years ended December 31:

	1984	*1983*
Investment in, and advances to, PACO, beginning of year	$131,396	$146,577
Additional investment in PACO		85,000
Advances to PACO	206,648	41,506
Net loss	(233,951)	(141,687)
Reserve for additional loss on note receivable, PACO	(104,093)	
Investment in, and advances to, PACO, end of year	$ —0—	$131,396

Through December 31, 1984 OSMA made investments in, and advances to, PACO totaling $569,252, all of which has been recognized as a loss, either through PACO operating loss or reserve against outstanding advances (notes receivable). See Note 12 for discussion of status of commitments.

Condensed financial information for PACO is as follows:

Condensed Balance Sheet

	December 31,	
	1984	*1983*
Assets	$ 714,478	$366,032
Liabilities	879,637	297,240
Shareholder's equity (deficit)	$(165,159)	$ 68,792

Condensed Statement of Operations

	Years Ended December 31,	
	1984	*1983*
Income	$644,727	$338,413
Expenses	878,678	480,100
Net loss	$233,951	$141,687

7. *Uncertainties Leading to Qualified Opinion:*
The financial statements of Physicians Administrative Corporation of Ohio — (PACO), a wholly-owned subsidiary of OSMA, were examined by other auditors who expressed a qualified opinion thereon. The reasons for their qualification are:

1. PACO incurred a significant net loss during the year ended December 31, 1984, and as of that date the Company's current liabilities exceeded its current assets by $311,653. PACO's management estimates the Company may experience negative cash flow from operations in the near future and may not be able to obtain additional financing. Therefore, PACO may not have sufficient resources to maintain operations. Their financial statements do not include any adjustments relating to the recoverability of asset carrying amounts or to the amount and classification of liabilities that might be necessary should the Company be unable to continue in existence.
2. As of December 31, 1984, the Company had a receivable of $91,000 from a financially troubled company relating to the sale of a software package and certain distribution rights. This balance due PACO has been acknowledged and a settlement is currently being negotiated. In the opinion of PACO's management, this receivable is realizable and thus, no allowance for doubtful accounts has been established. Because of this situation, it is not possible to ascertain the collectibility of this receivable.

Based on the uncertainties mentioned above, OSMA may become liable for $300,000 in notes due the bank by PACO, which OSMA has guaranteed.

Because of this uncertainty, the independent accountants of the OSMA have expressed a qualified opinion on the financial statements for the year ended December 31, 1984.

8. *Term Debt:*
Term debt at December 31, 1984 consisted of the following:

14.5% Mortgage loan payable in annual installments of $361,472, including interest, beginning December 1, 1983, collateralized by the assignment of rents and a security deposit from PICO (see Note 9) and due December 1, 1989. After December 1, 1987, the bank has the right to declare all unpaid principal and interest payable and OSMA has an unlimited right of prepayment	$2,414,017
8% Mortgage loan payable in monthly installments of $500, including interest computed semiannually, collateralized by land and building. OSMA has the right of prepayment	70,062
14.25% Commercial note payable in sixty monthly payments of $360, including interest, collateralized by the equipment purchased, and maturing September 21, 1985. OSMA has the right of prepayment.	2,843
	2,486,922
Less current portion	14,692
	$2,472,230

Maturities on term debt subject to mandatory redemption are as follows:

1985	$ 14,692
1986	13,543
1987	15,479
1988	17,693
1989	20,226

Balance sheet, 1984 and 1983

continued

Later years	2,405,289
	$2,486,922

9. *Leases:*
The Association leases office facilities and equipment with a net book value of $2,154,375 to PICO, a related party (Note 3), under terms of an operating lease. The office facility lease term is for twelve years expiring January 15, 1995, with monthly rent of $26,875. The equipment lease term is for ten years expiring January 15, 1993, with monthly rent of $3,600. PICO has the option to purchase the office facility and equipment at the end of the lease term for $2,155,000 and $50,000, respectively. The Association has the right to require prepayment of all rent at any time after the 60th monthly rent payment. Should OSMA exercise this option, PICO may purchase the facility and equipment at a price set forth in the lease agreement. PICO pledged bonds with a par value of $2,500,000 as security for the lease payments.

Future minimum rentals to be received from the above operating lease as of December 31, 1984 are as follows:

1985	$ 365,700
1986	365,700
1987	365,700
1988	365,700
1989	365,700
Later years	1,742,100
	$3,570,600

The Association leases the land on which the above facility is located from PICO under terms of an operating lease. The lease term is for 40 years expiring January 15, 2023 with monthly payments of $400. PICO has the option to terminate the lease in the event the above described option to purchase the facility from OSMA is exercised.

The following is a summary of the activity related to the above transactions for the years ended December 31:

	1984	*1983*
Rental income	$365,700	$365,700
Interest income	17,776	
	383,476	365,700
Expenses:		
Rent	4,800	4,800
Interest (Note 8)	352,150	334,239
Depreciation	78,250	78,250
	435,200	417,289
Net loss	$ 51,724	$ 51,589

During 1984 and 1983, the above described leasing transaction resulted in approximately $17,000 of positive cash flow to OSMA.

Additionally, OSMA leases automobiles and certain office equipment for terms of up to three years. Minimum annual rental commitments under these operating leases as of December 31, 1984 are as follows:

1985	$ 74,777
1986	46,695
1987	36,385
1988	29,442
1989	4,800
Later years	158,400
	$350,499

Rental expense for 1984 and 1983 was $96,497 and $93,043, respectively.

10. *Pension Plan:*
The Association maintains a trusteed noncontributory defined benefit pension plan for its eligible employees. The actuarial cost method used in determining the valuation of funding is the entry-age-normal with frozen-initial-liability method. The trustee of the Plan is American Physicians Life Insurance Company, a subsidiary of PICO and a related party to OSMA.

The total cost of the plan charged to operations in 1984 and 1983 was $111,486 and $106,294, respectively, which includes amortization of past service costs over approximately a thirty-year period.

A comparison of the accumulated benefits and net assets for the plan years beginning December 31, is as follows:

	1983	*1982*
Actuarial present value of accumulated plan benefits:		
Vested	$ 785,423	$708,160
Nonvested	73,681	62,409
Total	$ 859,104	$770,569
Market value of plan assets available for benefits	$1,042,419	$893,237

The assumed investment rate of return used in determining the actuarial present value of accumulated plan benefits was 8.0%.

11. *Ohio State Medical Journal:*
The income and expenses applicable to the operations of "Ohio State Medical Journal," for the year ended December 31, 1984, are:

Income:	
Advertising (net of commissions of $38,090 and cash discounts of $2,412)	$174,535
Subscriptions received from nonmembers	10,270
Membership subscriptions, allocated at $12 per dues-paying member (included in membership dues income on the Statement of Operations and Undesignated Net Worth)	218,388
	403,193
Expenses:	
Salaries, pension costs, payroll taxes and other employee benefits	116,228
Printing, postage, stationery, supplies, illustrations, engravings and consulting services	201,456
Building expenses, depreciation and other	56,316
	374,000
Excess of income over expenses, Ohio State Medical Journal	$ 29,193

12. *Subsequent Events — PACO:*
On June 25, 1985, PACO negotiated a payment of $49,152 related to the $91,000 receivable described in Note 7.

On August 24, 1985 PACO terminated all but three of its employees and subsequently vacated its leased office space. Its principal activity subsequent to these terminations has been to continue to provide limited tape to tape billing and physician placement services and attempts to sell the rights to its proprietary software. Although negotiations have taken place, as of November 5, 1985, no definitive agreement for sale of the software has been signed. Proceeds from the sale of this software will be used to repay bank debt guaranteed by OSMA in the amount of $300,000.

OSMA remains contingently liable for $300,000 of bank loans related to its guarantee of this debt of PACO. In addition, OSMA has approved additional advances of $50,000 to fund operations through December 31, 1985.

MEDICINE: WHERE DO WE GO FROM HERE?
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Resolutions Affecting the OSMA Constitution

Introduced By: OSMA Council
Subject: AMA Alternate Delegate to be Elected by OSMA Medical Student Section

WHEREAS, The OSMA Council has been impressed with the enthusiasm and dedication shown by Ohio students in the Medical Student Section of the OSMA; and

WHEREAS, Medical students contributed significantly to the deliberations of the Ohio Delegation to the AMA House of Delegates; and

WHEREAS, OSMA Council in conjunction with the Ohio Delegation to the AMA believe the delegation will be strengthened by input from the medical student community, therefore be it

RESOLVED, That one alternate delegate to the AMA be designated as a medical student alternate delegate to be elected by the OSMA Medical Student Section Assembly in accordance with the constitution and bylaws of the OSMA and the bylaws of the Medical Student Section; and be it further

RESOLVED, That the OSMA bylaws be amended as follows to allow for such election:

Chapter 4. **Section 7. Delegates to the American Medical Association.** The House of Delegates shall elect representatives to the House of Delegates of the American Medical Association in accordance with the constitution and bylaws of that body, EXCEPT FOR ONE ALTERNATE DELEGATE, WHO SHALL BE ELECTED BY THE MEDICAL STUDENT SECTION IN ACCORDANCE WITH THE CONSTITUTION AND BYLAWS OF THIS ASSOCIATION AND THE BYLAWS OF THE MEDICAL STUDENT SECTION.

Chapter 5. **Section 5. Nomination of Officers and Delegates and Alternate Delegates to the American Medical Association.** The report of the Committee on Nominations with respect to all offices, except that of President-Elect, and with respect to all Delegates and Alternate Delegates to the American Medical Association, EXCEPT FOR THE ALTERNATE DELEGATE ELECTED BY THE MEDICAL STUDENT SECTION, shall be posted at the registration desk of the Association at the earliest time practicable and at least three hours before the final session of the House of Delegates. Nominations for the office of President-Elect shall be made from the floor at the final session of the House of Delegates.

Each nominating speech for any office shall be limited to three minutes. Not more than one speech shall be made in seconding a given nomination and such seconding speech shall be limited to one minute.

Chapter 5. **Section 7. Election of Officers and of Delegates and Alternate Delegates to the American Medical Association.** The election of officers of this Association and of delegates and alternate delegates to the American Medical Association shall be by ballot. The election of delegates to the American Medical Association shall be conducted by means of a single ballot sheet and the election of alternate delegates shall likewise be conducted by means of a separate single ballot sheet. ELECTION OF ONE ALTERNATE DELEGATE TO THE AMERICAN MEDICAL ASSOCIATION BY THE OSMA MEDICAL STUDENT SECTION SHALL BE IN ACCORDANCE WITH THE BYLAWS OF THE MEDICAL STUDENT SECTION.

In the event there is only one position to be filled, the nominee receiving the majority of all votes cast shall be declared elected. In case no nominee receives a majority on the first ballot, the two nominees receiving the lowest number of votes shall be dropped and a new ballot taken; this procedure shall be continued until there are two nominees remaining. The nominee receiving a majority of all votes cast shall be declared elected.

In the event there is more than one position to be filled from among any number of nominees, a

nominee, in order to be declared elected, must receive the votes of a majority of those voting, provided, however, that if upon any ballot the number of nominees receiving a majority vote is greater than the number of positions to be filled on such ballot, those nominees (not to exceed the number of positions to be filled on such ballot) receiving the greatest number of votes shall be declared elected. If upon any ballot some but not all of such positions are filled, a new ballot shall be taken from among all of the remaining nominees; except that the two nominees receiving the lowest number of votes on the previous ballot shall be dropped on each new ballot until there are two more nominees than positions available, after which the nominee receiving the lowest number of votes shall be dropped. On every ballot a nominee, in order to be declared elected, must receive the votes of a majority of those voting, provided, however, that if upon such new ballot the number of nominees receiving a majority vote is greater than the number of positions to be filled on such ballot, those nominees (not to exceed the number of positions to be filled on such ballot) receiving the greatest number of votes cast shall be declared elected. If upon any ballot no nominee receives the votes of a majority of those voting, the two nominees receiving the lower number of votes shall be dropped and a new ballot will be taken; this procedure shall be continued until there are two more nominees than positions available, after which the nominee receiving the lowest number of votes shall be dropped; and this procedure shall be continued until all positions have been filled.

Chapter 8. **Section 5. Terms of office for medical student section alternate delegate.** The alternate delegate elected by the medical student section shall serve for a period of one year from the time of election. This alternate delegate shall be eligible for re-election so long as medical student status is maintained.

CHAPTER XV
AMA ALTERNATE DELEGATE

AN ALTERNATE DELEGATE TO THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES SHALL BE ELECTED BY MAJORITY VOTE FOR A ONE-YEAR TERM BY NOMINATION FROM THE FLOOR OF THE OSMA-MSS ANNUAL ASSEMBLY IN ACCORDANCE WITH THE OSMA BYLAWS.

DURING THE ELECTION PROCESS, THE OSMA-MSS PRESIDENT WILL PLACE A VOTE IN PRIVATE TO BE COUNTED ONLY IN THE EVENT OF A TIE. IN THE EVENT 3 OR MORE CANDIDATES ARE RUNNING AND A TIE BETWEEN TWO CANDIDATES FOR THE MOST VOTES IS TALLIED, THEN A RUNOFF ELECTION BETWEEN THE TOP TWO CANDIDATES SHALL FOLLOW. THE ALTERNATE DELEGATE ELECTED SHALL ASSUME OFFICE AT THE TIME OF ELECTION AND SHALL BE ELIGIBLE FOR RE-ELECTION SO LONG AS STUDENT STATUS IS MAINTAINED. ANY VACANCY SHALL BE FILLED BY AN OSMA-MSS MEMBER SELECTED BY THE OSMA-MSS GOVERNING COUNCIL UNTIL SUCH VACANCY CAN BE FILLED BY ELECTION AT AN OSMA-MSS ASSEMBLY.

Next month in:

THE Ohio STATE Medical Journal

Interprofessional Relationships: Merging roles, redefining relationships

Next month, the Journal takes a look at the changing roles of health-care professionals.

Physicians rising in public favor

The public appears to be less disgruntled with physicians than in the past, according to a recent public opinion survey conducted by the AMA.

In the survey, 64% of respondents reported a "loss of faith" in physicians as a whole — down from 68% in 1984. This small renewal of faith may have something to do with a renewal in communication between physicians and patients. Fifty percent of respondents — compared with 44% in 1984 — said physicians are communicating better.

In matters of money, 32% of those polled — up from 27% — said physician fees are reasonable.

And, speaking of money — are physicians too interested in it? Well, yes . . . said 62% — but not as much as before — down from 67% in 1984.

"You can do a lot more when you're happy."



Joan Sturgis, Osa Reimann and Frank Sturgis

Osa Reimann
82 years old, Assisted Living resident of Judson Retirement Community

"I was so worried about Aunt Osa," says Joan Sturgis. "We came over together from Denmark in 1937. Life had been good, but before moving to Judson, Aunt Osa was living alone in a big house in Long Island. She could hardly walk, and had few visitors. I'd talk to her every other day and drive up frequently to visit. But life had become a burden. She said she just wanted to die."

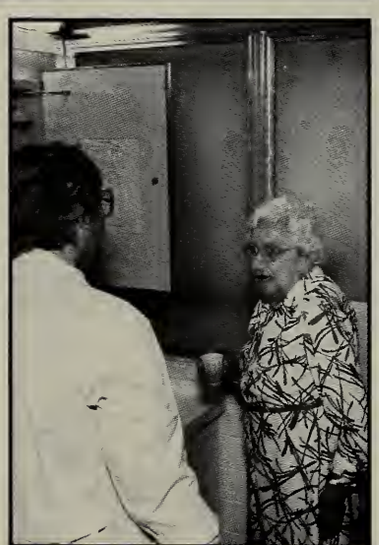
"Now I'm happy," says Aunt Osa. "I can walk much better. I eat well. I don't have to cook or do dishes. I have my own things. Many times when my niece calls me I'm down the hall visiting friends or taking part in an activity. I go to exercise class every day. I do as much as I possibly can."

"Aunt Osa has her own room at our house, too," says Frank. "She stays with us every Sunday and Monday. We have fun together whether we stay home or go out. And, when we take a trip, we don't worry about Aunt Osa. You know, the Danes make the most of each day. And that's what living at Judson is all about."

Assisted Living represents a new concept in retirement care. It provides a distinct option between independent living and nursing care for individuals with some physical or cognitive limitations. Support is provided when and where needed. For more information on Assisted Living at Judson, contact our Admissions Director.



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Handrails enhance mobility



Group activities



Laundry assistance

AMA's Hospital Medical Staff Section

The AMA-Hospital Medical Staff Section's (AMA-HMSS) Sixth Assembly, entitled "Physicians in the 90s," met December 6-8, 1985 in Washington, D.C. The HMSS is the newest and fastest growing section of the AMA. Delegates representing individual hospital medical staffs from more than 40 states gathered to discuss the special concerns of physicians in hospital settings and other "grassroots" medical issues.

The HMSS Reference Committees and the General Assembly considered 54 resolutions on subjects ranging from the legal status of the medical staff to the recent Massachusetts legislation requiring Medicare assignment as a precondition of licensure. The HMSS General Assembly sent seven resolutions to the AMA House of Delegates for their consideration.

The Ohio Delegation to the HMSS is chaired by Edmund W. Jones, MD, of Cincinnati, who represents the Bethesda Hospital. Ohio delegates were from a wide range of hospitals across the state, representing both large and small facilities and all areas of the state.

As part of the "Physicians in the 90s" program, HMSS delegates were addressed by Dennis S. O'Leary, MD, dean of Clinical Affairs at George Washington University Hospital and President-Designate of the Joint Commission on Accreditation of Hospitals, and Eric W. Berkowitz, PhD, professor of Marketing at the University of Massachusetts. Dr. O'Leary spoke to the delegates on the future role of the JCAH in preserving the quality of patient care as the focus of medicine moves out from the hospital to a myriad of outpatient settings. Dr. Berkowitz presented the delegates with an eye-opening forecast of medical care in the future and the changing role of the physician.

The Ohio State Medical Association's Hospital Medical Staff Section will meet on May 2, 1986, prior to the OSMA Annual Meeting. Hospitals are encouraged to begin the process of selecting Delegates and Alternate Delegates for the May HMSS meeting. All Ohio hospitals are entitled to credential one Delegate and one Alternate Delegate. If there are any questions on the process of delegate selection, please contact the OSMA office.

—Douglas Graff, JD

The Physician and Antitrust

By Douglas Graff, JD

Federal Antitrust Law and Hospital Medical Staff Actions

Federal and state antitrust laws have been applied to manufacturing and industrial concerns since the late 19th century. Application of antitrust principles to health care providers is still in its infancy. Only since the mid-1970s have the actions of hospitals and medical staffs been examined under the scrutiny of federal and state antitrust laws. The Department of Legal Services has compiled the following information on the nature and effects of antitrust laws to help inform physicians of the broad scope of the antitrust statutes. This column is not intended to be a legal opinion on any particular factual situation of any particular hospital. Hospitals and medical staffs should consult with their legal counsel concerning the appropriateness of any actions proposed or taken which may have anti-competitive effects.

This column will briefly define the principles of antitrust law and trace the progression of health care antitrust through history, focusing on the effect that antitrust laws have had on medical staff membership and clinical privilege decisions by hospital medical staffs.

I. Introduction to Antitrust Law

The purpose of antitrust laws is to eliminate practices that interfere with free competition in the marketplace. The laws are designed to promote a vigorous and competitive economy in which all businesses have a full opportunity to compete against each other on the basis of price, product, quality, and service.

The United States Congress enacted a group of antitrust statutes beginning in the late 19th century to curb the perceived abuse of large industrial and manufacturing operations that were able to drive their competitors out of the market by unfair methods of competition. Federal and state antitrust laws were enacted to protect competition and to preserve the free market system, not to protect individual competitors. In theory, competitive markets are maintained by prohibiting monopolies, price-fixing, boycotts, and other restraints on free trade.

There was no application of antitrust principles to health care for almost 80 years because several legal doctrines were believed to preclude their application. First, and the most important, was that the practice of "learned professions" were not considered to involve "trade or commerce" and thus exempt from antitrust laws. Early United States Supreme Court cases seemed to indicate that the professions were exempt. In *Goldfarb v. Virginia State Bar Association,* 421 U.S. 773 (1975), the U.S. Supreme Court held that the fact that a profession (in that case lawyers) was involved did not prevent application of antitrust laws. The Court wrote:

> The nature of an occupation alone, does not provide sanctuary from the antitrust laws . . . nor is the public service aspect of professional practice controlling in determining whether antitrust laws include professions. *Id.* at 787.

However, the Court in a footnote in *Goldfarb* seemed to indicate that professions may not be held to the same standards as other business ventures.

Second, the practice of learned professions were most often local in character and any effect on interstate commerce was incidental. This was important since federal antitrust laws were only applicable to cases involving trade or commerce "among the several states." In 1976, the U.S. Supreme Court in *Hospital Building Co. v. Trustees of Rex Hospital,* 425 U.S. 738 (1976), held that the actions of even a single hospital were able to be viewed as sufficiently affecting

interstate commerce to warrant application of antitrust principles. The purchase of out-of-state medicines and supplies, out-of-state third party reimbursement, payment of management fees to an out-of-state parent company, and the financial arrangements with out-of-state lending institutions combined to have a substantial effect on interstate commerce.

A third reason that health care was not subject to federal antitrust scrutiny was that the delivery of services by learned professions was regulated by state licensing laws. Areas under state regulation are exempt from antitrust laws. However, the U.S. Supreme Court has narrowed this exemption to conduct which the state actively compels and supervises, not those in which the state merely acquiesces. See *Bates v. State Bar of Arizona,* 433 U.S. 350 (1977).

Finally, many health care institutions are not-for-profit institutions. Other not-for-profit institutions had been granted a limited exemption to the antitrust statutes. While the courts never wholly endorsed this exemption, a combination of this factor and the lack of a substantial effect on interstate commerce often had precluded application of antitrust principles. However, the currently enacted version of Section 4 of the Federal Trade Commission Act applies to entities which are for-profit or for the profit of its members, which has been interpreted to include most health care institutions which are not conducted entirely for charitable purposes.

All these court cases in the mid-1970s have left two very important benchmarks in health care antitrust. First, the traditionally recognized exemptions and defenses have been greatly eroded, thus allowing antitrust principles to be applied to health care. Second, health care providers are viewed as "competing" with each other in the marketplace for delivery of health care services. Antitrust principles will be applied to the acts of competitors and their trade associations to ensure that competition is not lessened.

II. The Antitrust Laws

The principal federal antitrust statutes are the Sherman Act, the Federal Trade Commission Act, the Clayton Act, and the Robinson-Patman Act. The Sherman Act and the Federal Trade Commission Act are the ones most often applied to the health care area. Approximately half of all pending antitrust lawsuits in the health care area involve challenges by individual practitioners to medical staff privilege decisions. This review will focus on the suits brought under Section One of the Sherman Act which may be brought by rejected applicants for clinical privileges or staff membership.

The denial or revocation of clinical privileges or staff membership may be challenged as a "group boycott." Boycotts are "concerted refusals to deal"; i.e. arrangements to exclude competitors, purchasers or sellers from the market. Typically, conduct will be characterized as a boycott when an existing business relationship is used to exclude competition. It should be noted, however, that there are other grounds for an antitrust suit involving a denial of clinical privileges or staff membership, but group boycott allegations are the most common.

The Sherman Antitrust Act is the original antitrust statute and remains the most important provision in the antitrust area. This is the most commonly used federal antitrust statute for cases involving staff privilege questions. Section One of the Sherman Act states that "every contract, combination, . . . or conspiracy, in restraint of trade or commerce . . . is hereby declared illegal." Violation of the antitrust statutes may result in both criminal and civil penalties. Only the government may bring a criminal action for a violation. This column will deal only with civil actions that may be brought by an individual against the hospital, the medical staff, or individual physicians.

In order to establish a civil violation under Section One of the Sherman Act, the plaintiff must prove both an agreement or other joint action, and demonstrate an anti-competitive activity. Historically, hospitals were protected from antitrust actions because Section One requires two or more actors with independent economic interests. A hospital, along with its medical staff and governing board, was considered one economic unit and incapable of conspiring with itself. Therefore, when a hospital, upon the recommendation of the medical staff, decided to grant or deny medical staff membership or clinical privileges, the hospital could not be held liable under Section One of the Sherman Act since no "conspiracy" occurred.

Recently, however, the courts have recognized an exception to the general rule. In *Arizona v. Maricopa County Medical Society,* 457 U.S. 332 (1982), the U.S. Supreme Court allowed antitrust liability to be imposed when an anti-competitive decision is made by an employee, officer, or member who also has an independent economic interest in the decision. Although this case involved price-fixing and not a group boycott, it is significant to note that the court looked beyond the unified economic structure (i.e. the foundation for medical care) established to administer the health plan, to the physician members involved. The Court found that the foundation for medical care was in reality a group of competitor physicians conspiring to fix prices.

After *Maricopa,* courts have been more willing to consider allegations that the hospital and the members of the medical staff are potentially conspiring. When a hospital makes clinical privilege determinations and staff

membership decisions through groups of "competitors" of the applicant, e.g., orthopedic surgeons determining clinical privileges of podiatrists, the courts may consider the medical staff review of an application for clinical privileges or staff membership as a review by two or more separate economic entities which are capable of conspiring. This analysis would fulfill the first of the two necessary elements in an antitrust lawsuit. Therefore, if the plaintiff can show an anti-competitive purpose or effect, the defendants may be liable for triple the amount of actual damages suffered, plus the plaintiff's attorney fees.

Hospital governing boards and medical staffs should understand their roles and responsibilities in the application review process to avoid antitrust liability. Medical staffs have the expertise to determine the professional competence and abilities of current members of the medical staff as well as applicants for clinical privileges and medical staff membership. Joint Commission on Accreditation of Hospital (JCAH) standards, referenced in Ohio's hospital licensure laws, require that the medical staff, through the Department Chairpersons and Executive Committee structure, make recommendations on the clinical privileges for each individual. It is the responsibility of the hospital governing board to independently review each applicant or application for re-appointment. While the hospital governing board should be guided by the recommendations of the medical staff, the board should determine whether the individual applicant is suited for inclusion in the hospital, based on the additional factors of the hospital's need for the particular recommended clinical privileges, the hospital's ability to provide support for the applicant in terms of allied personnel and equipment, and the hospital's ability to provide for patient care needs in the community.

Both the hospital board and the medical staff must perform their tasks separately. While there are overlapping concerns, the antitrust statutes require the decisions to be made independently in order to avoid liability. The thrust of antitrust law focuses on the collusion of separate economic entities or units acting in a concerted manner.

III. Antitrust Standards

There are two standards which a court can apply when determining whether certain activity violates antitrust law: (1) the *per se* standard, or (2) the "rule of reason" standard. Which standard the court applies is extremely important, since it determines whether or not the court will consider the reasons for the hospital's or medical staff's actions. If there is a *per se* violation, the court will refuse to consider any positive benefits derived from the hospital or medical staff action. In *per se* cases, if the court determines there has been a violation, the only decision left to make is how much the hospital or medical staff should be assessed in damages.

If two or more separate economic entities act jointly in a manner which is considered to be inherently anti-competitive, it is a *per se* violation. The *per se* violation can exist even if the action in fact encourages competition or provides other economic benefits or incentives. Joint actions that are generally *per se* violations include price-fixing, dividing markets, and some forms of boycotts.

Those actions not considered inherently anti-competitive are judged by the "rule of reason" standard. The court weighs the pro-competitive and anti-competitive effects of the arrangement and its purpose. If the record reveals some plausible justification for the medical staff action, then a court's evaluation of the decision should be made under a rule of reason analysis.

Application of the principles of antitrust law to health care has been imprecise. Health care products and markets, as well as public welfare and concerns for patient well-being, have all been factors which courts have wrestled to fit into the antitrust analysis.

IV Major Privilege Cases

One of the major medical staff membership and clinical privilege cases in which the court thoroughly reviewed the antitrust principles under a "rule of reason" analysis was *Robinson v. Magovern,* 521 F. Supp 842 (W.D. Pa. 1981), *aff'd.* 688 F.2d 824 (3rd Cir. 1982).

Robinson, a thoracic surgeon, was denied clinical privileges and staff membership at Allegheny General Hospital. He brought suit against the hospital, Dr. Magovern, (the Director of the Department of Surgery and a cardiac surgeon), the Board of Trustees and members of the medical staff for an alleged boycott and a monopoly under the Sherman Antitrust Act.

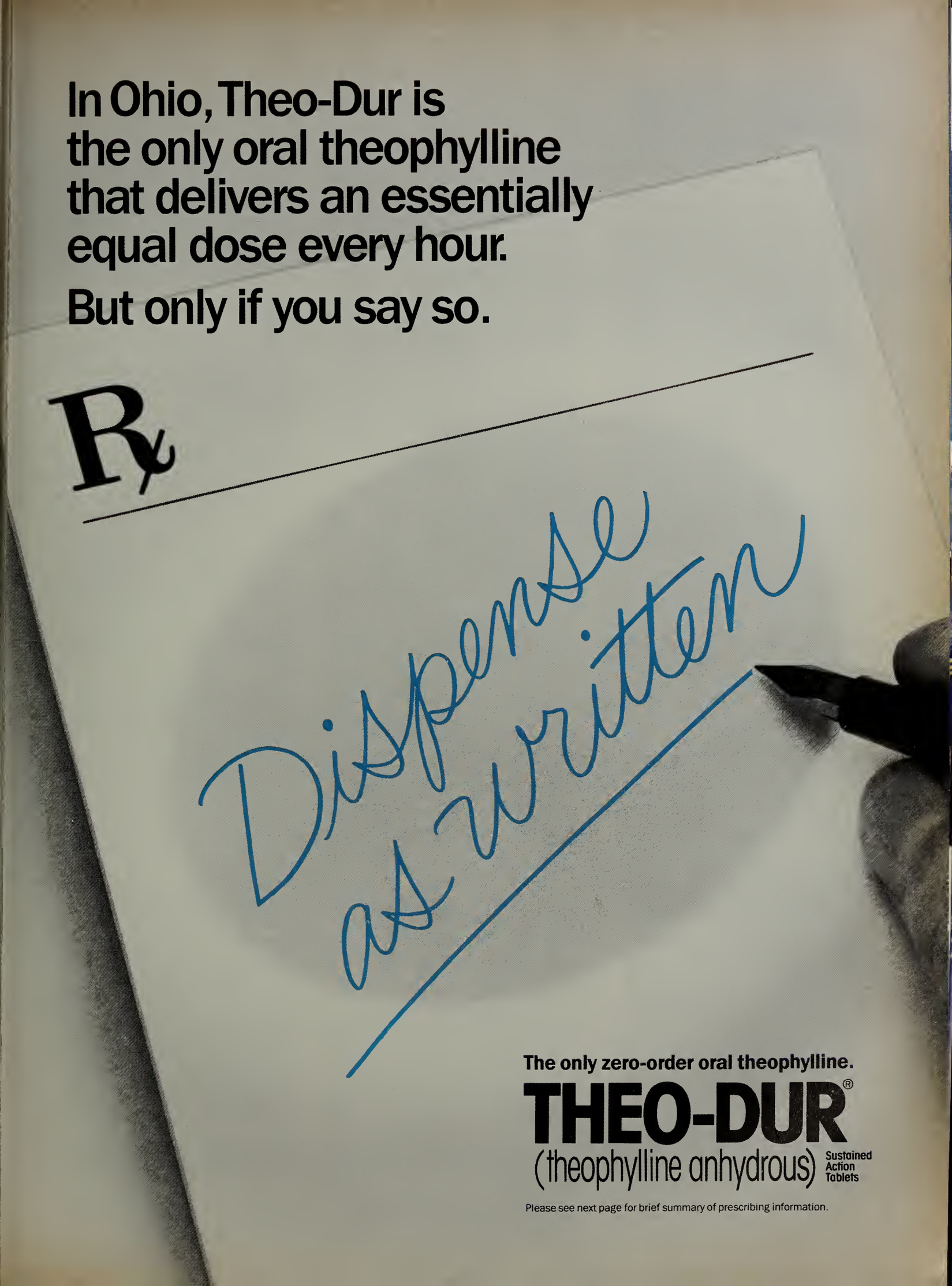
Antitrust analysis requires the court to identify the relevant product market and relevant geographic market. In the *Robinson* case, the court found that adult open heart surgery was the relevant product and that surgeons were precluded from supplying open heart services independent of the hospital.

The court next addressed the geographic market in which Dr. Robinson and the defendants practiced. The larger the geographic market, the more difficult it is to show a negative effect on competition. Dr. Robinson contended that only the patients and facilities of Allegheny General Hospital should be included in determining the affected market. The defendants argued that the entire country should be included, since patients were willing to travel to any center in the nation for appropriate care.

The court looked at the referral patterns of practicing physicians in the Allegheny General Hospital area and the different capabilities of community, tertiary and

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teaching hospitals. The court found that referrals were clustered in and around a 16-county area including parts of Ohio, Pennsylvania, and West Virginia. There were six other facilities in this area that performed adult open heart procedures. It was these seven facilities which formed the relevant geographic market, the court concluded.

The final decision in the case was that Robinson was not illegally denied clinical privileges and staff membership at Allegheny Hospital. The court found that there was not a specific intent on the part of the defendants to monopolize adult cardiac surgery nor to boycott Robinson. With the availability of six other facilities in the relevant geographic market, Dr. Robinson would be able to compete effectively with Dr. Magovern and the other defendants by applying for and being granted clinical privileges at another facility. (Dr. Robinson had been granted privileges in some of the other institutions.)

The court recognized that the hospital and the groups of surgeons who perform open heart surgery in the hospital are separate economic units. The court found that as Director of the Department of Surgery, Dr. Magovern, "wears two hats at Allegheny General." When acting as Director, Dr. Magovern was an agent of the hospital, and therefore not capable of a conspiracy with the hospital. However, Magovern did have an independent, personal stake in the action taken by the hospital.

The court held that a concerted activity takes place when one economic entity takes an action at the request of a second economic entity. Yet, where separate, independent reasons exist for the action taken, no concerted activity has occurred, even when the second entity requested that the first entity take the action. Here, the court found plausible reasons for the hospital's denial of clinical privileges and staff membership to Robinson.

It is important to note, though, in another major clinical privilege and staff membership case, the *per se* standard was applied. *Weiss v. York Hospital,* 745 F.2d 820 (3rd Cir. 1984) concerned the exclusion of osteopaths from clinical privileges and medical staff membership. The York Hospital medical staff had instituted a restrictive policy with different admission standards for D.O. and M.D. physicians. Even when osteopaths were granted clinical privileges, they were treated as lesser practitioners. The court found that such treatment adversely impacted on osteopathic applicants. The critical factor for the court was that the hospital offered no legitimate justification for the medical staff's actions.

The hospital stated that the reason for rejecting Dr. Weiss, an osteopathic physician, was personality problems. The only evidence was secondhand hearsay from unnamed patients, and no problems were documented pertaining to the professional competency of Dr. Weiss. The record revealed extensive evidence regarding different levels of scrutiny applied to M.D. and D.O. physicians. The court held that the procedures utilized to review the applications from osteopaths constituted concerted refusals to deal and a *per se* violation.

The Court decided that "as a matter of law, the medical staff is a combination of individual doctors and therefore, any action taken by the medical staff satisfies the 'contract, combination, or conspiracy' requirement of Section 1." Under this decision, a plaintiff need only prove an anti-competitive effect or purpose in order to prevail in the suit.

The facts of the *Weiss* case established a pattern or practice of excluding a class of practitioners with little documented reasons. This differs from the *Robinson* case, in which the affected party was only one person, rather than a class of individuals. This may be the reason for the court's

application of the stricter *per se* analysis in the *Weiss* case. However, the reasons for using different standards in the two cases is not explained by the court.

There is another recent case which will affect the standard courts use in determining whether there has been an antitrust violation. The United States Supreme Court, in *Northwest Wholesale Stationers v. Pacific Stationery and Printing,* 105 S. Ct. 2613, (decided June 11, 1985), reviewed the application of the *per se* standard to alleged boycotts. While the case did not arise in the health care context, the opinion may have profound effects on health care providers.

In *Northwest,* the defendant, Pacific Stationery, is a regional purchasing cooperative of office supply retailers. Members and nonmembers could purchase from the cooperative, but only members shared on a percentage basis in the profits which were distributed at the year's end. In effect, the members paid a lower price for supplies. Plaintiff, Northwest, was expelled from the group without explanation, notice or hearing. Northwest suffered approximately $10,000 in lost profits over the first year. Northwest filed a federal antitrust suit alleging a group boycott.

The U.S. Supreme Court decided that although a group boycott had occurred, that fact alone was not sufficient to impose antitrust liability. The Court held that "unless the cooperative possesses market power or exclusive access to an element essential to effective competition, the conclusion that expulsion is virtually always likely to have an anti-competitive effect is not warranted . . . Absent such a showing with respect to a cooperative buying arrangement, courts should apply a rule of reason analysis."

Therefore, under the Court's holding in *Northwest,* a person bringing an antitrust suit must now show that the challenged activity falls into a category "likely to have predominantly anti-competitive effects." The mere allegation of a boycott does not suffice because not all boycotts are predominantly anti-competitive. This places the burden on plaintiffs to show that an expulsion has cut them off from access to the market or made them unable to compete effectively.

V Conclusions

The conclusions of the U.S. Supreme Court in the *Northwest* case may signal a change in the focus of antitrust cases. It remains to be seen how broadly the lower courts will apply the Supreme Court's conclusions in Northwest to health care cases. It appears that trial courts will review the relative market power of a defendant prior to the choice between per se and rule of reason analysis to be applied. Assuming that the defendant does not control or dominate the market, the court will then look for evidence of the actual purpose of the activity. Arguably, if the denial or revocation of staff membership or clinical privileges plausibly makes the hospital more competitive, the hospital and the medical staff may be able to avoid liability.

However, the hospital and medical staff should carefully document and justify their decision thoroughly. The court will weigh the evidence from which an anti-competitive intent can be inferred against whatever pro-competitive purpose the hospital can document. In the absence of a legitimate explanation, documented and medically justifiable, the courts may infer that the conduct resulted from an anti-competitive purpose.

Because facts may vary from one case to another, the outcome of any antitrust challenge is difficult to predict. However, documentation of the justification for medical staff decisions is one of the best ways to lessen antitrust risk. A justification that embodies the overall policy and interests of the hospital is less likely to be viewed as anti-competitive than one that reflects the interests of part of the medical staff alone. Among the reasons the courts have considered pro-competitive include decisions based on an applicant's medical ability and professional conduct. Decisions based upon a concern for the provision of effective and efficient medical care in the hospital have also been upheld.

The application of antitrust principles to health care practitioners and institutions will continue in the future. The denial or revocation of clinical privileges or staff membership to any practitioner may be subject to a court challenge. The decision made by hospitals and medical staffs must be made on objective, demonstrated non-discriminatory principles that are documented in the record.

As allied practitioners and other providers attempt to enter the health care service area, all actions which may preclude entry will be closely scrutinized under the principles of antitrust law. Only by vigilant adherence to neutral and objective professional standards for patient care and a two-tiered review of applicants by medical staffs and the hospital governing board will exposure to antitrust liability be lessened.

Doug Graff, JD, Assistant Staff Counsel, Department of Legal Affairs

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WILLIAM T. BACON, MD, London, has been elected vice president of the 1985 board of trustees of Peer Review Systems, Inc., a non-profit physician membership organization to provide peer review and quality assurance.

ROLAND CARLSON, MD, Cleveland, has received the Distinguished Service Award for 1985 from the Academy of Medicine of Cleveland. Dr. Carlson was chosen for his special service to the academy and to organized medicine.

New members *(continued)*

Carl D. Porter
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Joseph A. Ridgeway
Bradley J. Riley
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Gregg M. Santilli
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Eric C. Schroer
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George D. Sifri
Janet J. Silbergeld
Lorri Sills
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Renu Sinha
Norman A. Smyke
Jeffrey W. Spychalski
Jean E. Starr
John R. Stechschulte
Jeffrey E. Stedwill
Harold C. Stevens
Roger S. Stienecker
Maureen E. Stubbs
Mary K. Subler
Ken T. Takegami
Susan D. Tener
Lynn R. Thomas
Craig R. Thompson
Cecily M. Tobin
Karen Tobin
Sharon K. Uhle
Cathy L. Vendeland
Francis A. Voegele
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Elizabeth F. White
Gary A. Wilson
Roger D. Wilt
James D. Wines
Terry E. Wiseman
James R. Wolfe
Michael D. Yokum
James R. Young

HAMILTON
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James T. Saul, Toledo
George M. Seal, Cleveland

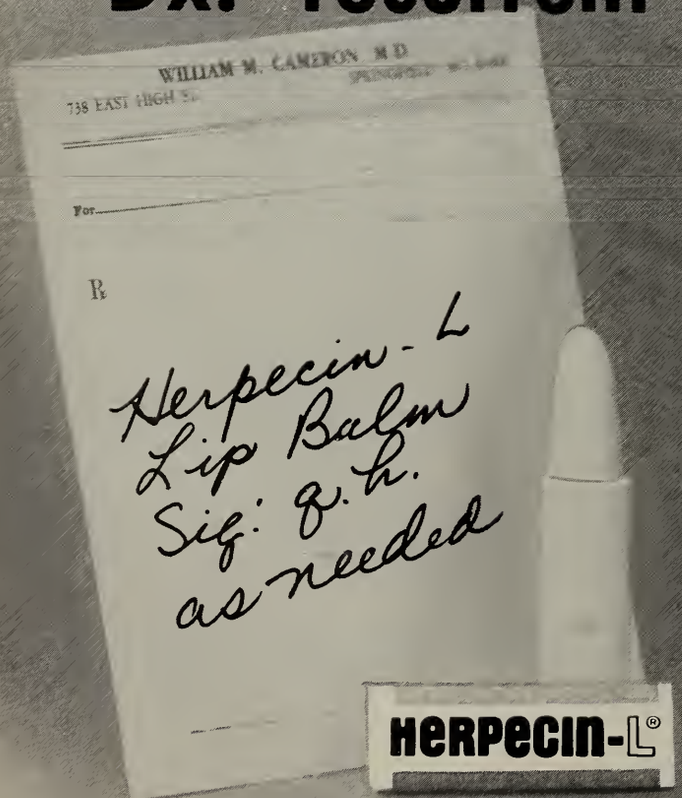
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Obituaries

ALVIN DUNBAR, MD, Cincinnati; University of Cincinnati College of Medicine, 1944; age 66; died November 13, 1985; member OSMA and AMA.

PASQUALE A. FERRARA, MD, Aurora; Case Western Reserve University School of Medicine, 1936; age 76; died November 6, 1985; member OSMA and AMA.

NORMAN E. FISHER, MD, Toledo; University of Michigan Medical School, Ann Arbor, Michigan, 1923; age 60; died November 23, 1985; member OSMA and AMA.

GEORGE T. HARDING, SR., MD, Worthington; Loma Linda University School of Medicine, Loma Linda, California, 1928; age 81; died November 27, 1985; member OSMA and AMA.

CARL A. LINCKE, MD, Carrollton; Ohio State University College of Medicine, 1931; age 79; died November 27, 1985; member OSMA and AMA.

IVAN G. LUST, MD, Hudson; Case Western Reserve University School of Medicine, 1929; age 81; died October 10, 1985; member OSMA and AMA.

ARSHAD MAJID, MD, Cleveland; King Edward Medical College, Lahorre, West Pakistan, 1981; age 28; died December 3, 1985; member OSMA and AMA.

ERNEST C. REED, MD, Dayton; Northwestern University Medical School, Chicago, Illinois, 1928; age 91; died November 23, 1985; member OSMA and AMA.

G. VERNON SMITH SR., MD, Cleveland; Ohio State University College of Medicine, 1922; age 92; died October 30, 1985; member OSMA and AMA.

FREDERICK WACHTER, MD, Painesville; University of Tennessee Center for Health Sciences, Memphis, Tennessee, 1943; age 67; died November 17, 1985; member OSMA and AMA.

WILLIAM R. WHITAKER, MD, Dayton; University of Cincinnati College of Medicine, 1953; age 62; died November 23, 1985; member OSMA and AMA.

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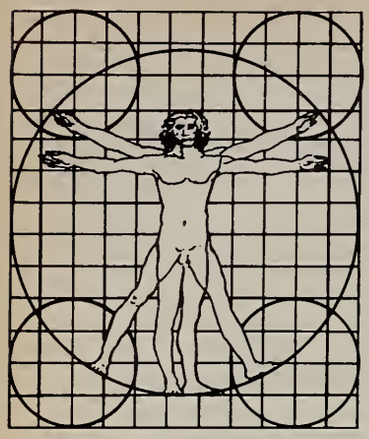
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Oncology Clinical Nurse Specialist
Oncology Program Director
Western Pennsylvania Hospital

David Seymour Ettinger, M.D.
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CLINICAL & SCIENTIFIC

RETROSPECTIVE REVIEW OF THE SENSITIVITY OF BARIUM ENEMA EXAMINATION IN A COMMUNITY HOSPITAL SETTING

Jeffrey R. Hallman, MD
Willard J. Howland, MD
Bruce H. Wolf, MD

Most studies of false-negative barium enema exams originate from university hospital settings. This community hospital-based study was accomplished via retrospective review of radiological diagnosis in pathology-proven neoplasms of the colon at Aultman Hospital. One hundred twenty cases of pathologically proven colonic neoplasms yielded 84 cases with prior barium enemas. Twelve false-negative cases were discovered yielding a 14.3% overall false-negative rate. The causal factors identified included technical factors, interpretive errors (distractions), perceptual errors and non-visible lesions.

Introduction

The evidence that survival can be improved in cases of colorectal carcinoma by early detection[1,2] has aroused much interest in diagnostic modalities for early detection as well as some controversy as to the efficacy of these methods relative to one another.[3,4]

As a portion of the continuing quality assurance program at Aultman Hospital, a retrospective review of barium enema examinations in pathologically proven cases of colorectal cancer was undertaken in order to ascertain the effectiveness of the Radiology Department in colon cancer diagnosis.

Aultman Hospital is a 687-bed community hospital with an average daily census of 635 throughout 1982. The Radiology Department consists of 11 full-time staff and eight residents who perform an average of 3,421 barium enemas yearly.

The primary goal of this retrospective study was to ascertain the sensitivity of lower G.I. examinations at this institution in comparison to previously reported false-negative percentages. The secondary goal was to identify causal factors relating to the radiologic misdiagnosis, in order to improve the efficacy of barium enema examinations.

From the Northeastern Ohio Universities College of Medicine at Aultman Hospital, Canton, Ohio.

Materials and Methods

The pathology reports of all colonic neoplasms from November 1982 to December 1983 were obtained and reviewed. These included both endoscopic biopsy reports as well as surgical specimen reports.

The available lower G.I. studies of 120 pathology-proven cases of colorectal neoplasm were reviewed for correlation of the radiologic findings with the pathologic diagnosis to determine the accuracy of interpretation.

Information gleaned from the pathology reports included (1) patient's name, sex, age, (2) endoscopic vs. surgical specimen, (3) tissue diagnosis, tumor location and spread. Each pertinent radiologic study was then reviewed to assess the appropriateness of the interpretation.

By using the pathology report of tumor location the region of interest on the barium enema examinations could be defined and studied in detail. All cases were reviewed by at least two of the authors to ascertain the visibility or non-visibility of false-negative studies. Of 120 cases with pathologically proven colon cancers, 84 cases had had barium enemas. Of these 84, 64 were single contrast and 20 were double contrast barium enema examinations.

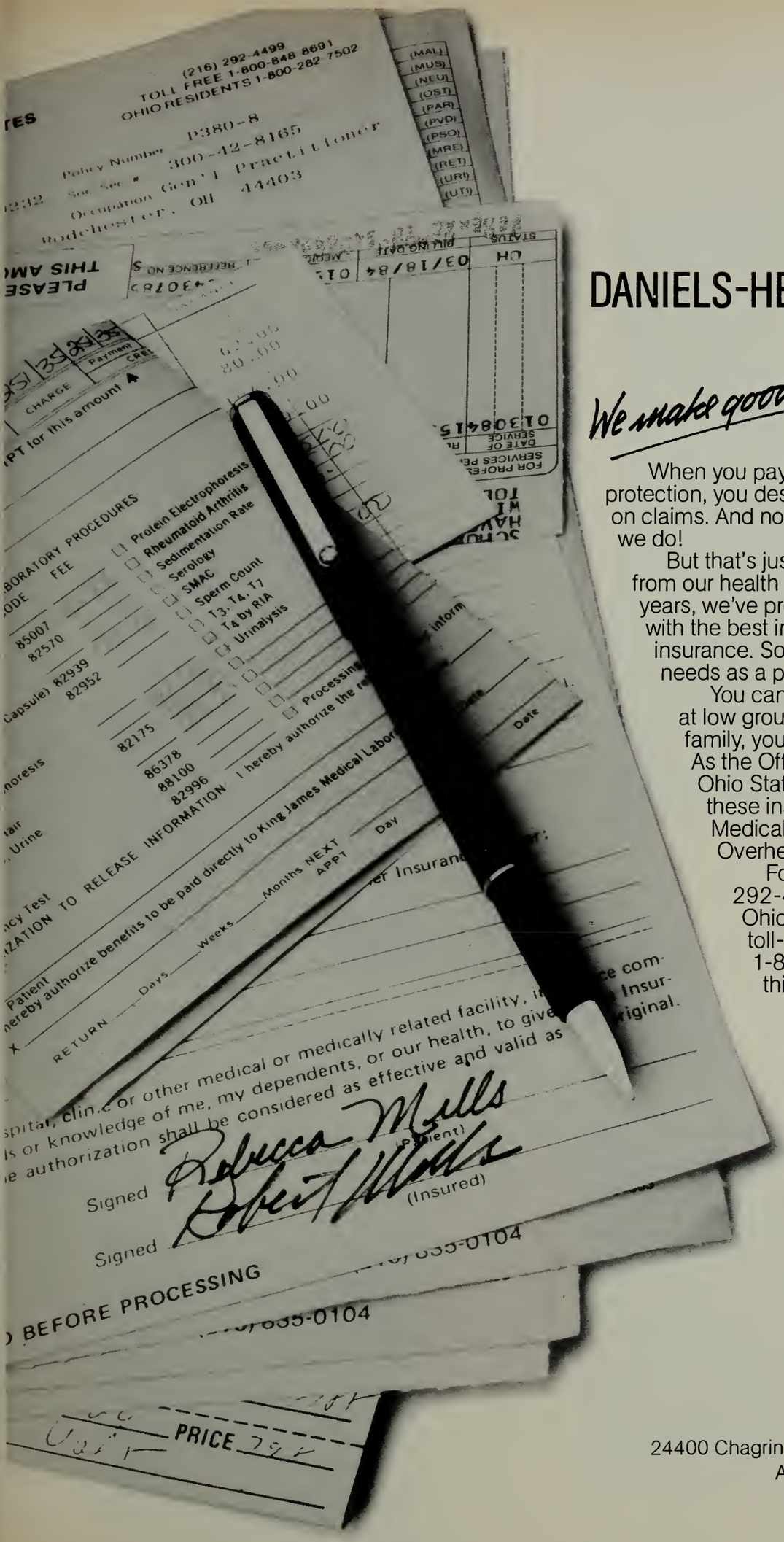
Forty-three males and 41 females had pre-surgical radiologic studies; 17 males and 19 females did not have pre-surgical barium exams available for review. Those with barium enema studies had an age range of 40 to 93 with a mean age of 67 years.

Patient preparations at this institution routinely include a 24-hour clear liquid diet and usage of a barium enema prep kit available at most pharmacies. A pre-examination plain film of the abdomen is obtained for determination of residual fecal material, and colonic lavage is done on patients as necessary.

Routine overhead views for air-contrast studies include PA, RAO, LAO, left lateral cross-table, prone-angled sigmoid right and left decubitus and post evacuation. Spot films vary as dictated by what is seen on the routine views. Removal of the enema tip prior to obtaining radiographs is always desirable, but often not possible due to elderly patients inability to retain introduced air if the balloon tip is deflated and removed.

Undiluted barium sulfate in a 55% W/W* mixture is used for the air-contrast studies.

The routine positions used for overhead views at this institu-



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tion include the projections necessary for at least 95% accuracy as per Thoeni and Petras.[12]

Single contrast barium studies contain the same routine overhead views with the exclusion of the right and left decubitus projections. Generally, a greater number of spot films are obtained with each study compared to double-contrast enemas.

Results

Seventy-two of the initial 84 cases demonstrated a radiographic abnormality interpreted as colonic neoplasm, or possible neoplasm.

In searching for causes of error in the 12 misdiagnosed cases, several factors were studied, including technical factors, perceptual errors, interpretive errors (distractions) and non-visibility of the lesion.

Technical factors include retained fluid and air from pre-enema sigmoidoscopic examination precluding adequate mucosal coating (two cases), and obscuration of the lesion by an inflated rectal balloon (three cases). Surprisingly, no false-negative cases in this study resulted from poor colonic preparation. Colonic lavage is done routinely before all barium enemas, whenever possible or necessary. Figures 1, 2.

TABLE I

Tumors by Location	This Study	Methodist Hospital 1983[17]	Abrams 1979[6]	Morgenstern 1978[5]
Cecum & ascending colon	17 (20 %)	428 (18.6%)	69 (33%)	247 (24%)
Transverse colon (includes both flexures)	3 (3.6%)	291 (12.7%)	15 (7%)	163 (16%)
Descending colon	11 (13.1%)	150 (6.5%)	16 (8%)	71 (7%)
Sigmoid	36 (42.8%)	599 (26.1%)	53 (25%)	379 (38%)
Rectum	17 (20.2%)	830 (36.1%)	58 (27%)	149 (15%)

There were 12 false-negative cases yielding an overall 14.3% false-negative rate. For single-contrast exams, nine of 64 cases gave 14.1% false-negative rate, and three of 20 double-contrast exams yielded a 15% false-negative rate. The locations of the tumors not seen initially were six rectal, five sigmoid and one transverse colon neoplasms.

Eighty-two of the 84 cases (98%) were adenocarcinomas and two cases (2%) were primary lymphomas of the colon.

The locations of the tumors in the cases with pre-surgical studies are summarized in Table I.

TABLE II

False-Negative Case Locations	Number	Percentage
Cecum and ascending	0	0
Transverse	1	8%
Descending	0	0
Sigmoid	5	41.6%
Rectum	6	50%

Discussion

The false-negative rate of 14.3% obtained in this study can be interpreted as falling within the expected percentage of 4 to 20%.[4,7,8,9,10,11,14]

Double-contrast method is adequate for examination of the rectum.[14,4] Although the rectal area is usually excluded when assessing the accuracy of single-contrast barium enemas, it is included in this 14.3% false-negative figure to allow determination of lower G.I. sensitivity overall. Excluding rectal tumors in single-contrast exams reduces the overall false-negative rate to approximately 7%.

There were no significant differences in the comparison of sensitivity between single-contrast studies (14.1%) and double-contrast studies (15%), corresponding to the findings of Johnson, et al at the Mayo Clinic,[4] although the number of cases in this study are actually too small to be significant.

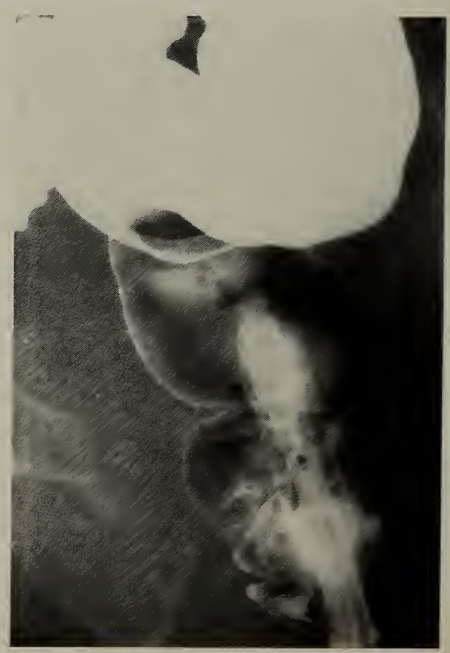
Further scrutiny of the 12 false-negative cases in this study showed that 50% were tumors with a rectal location, 41.6% sigmoid, and 8% transverse colon in location (one case), as summarized in Table II. These findings are also consistent with previous statistics.[8,10,12] The fact that one-half of all the non-detected cases were rectal in location might argue for the value of digital examination prior to enema tip insertion.[13] Of interest was the fact that two of the three double-contrast false-negative cases were tumors within 24 cm. of the anorectal junction and were easily identified in retrospect. This favors the view that an adequately performed double-contrast study is an accurate method for diagnosis of rectal carcinomas.[14]

*Liquid Polibar, E-Z-EM Co., Westbury, N.Y.



Figure 1

Two views of the rectosigmoid area with a subtle defect along the left lateral rectal wall. Originally thought to be the deflated enema tip balloon. This defect was in fact a carcinoma.



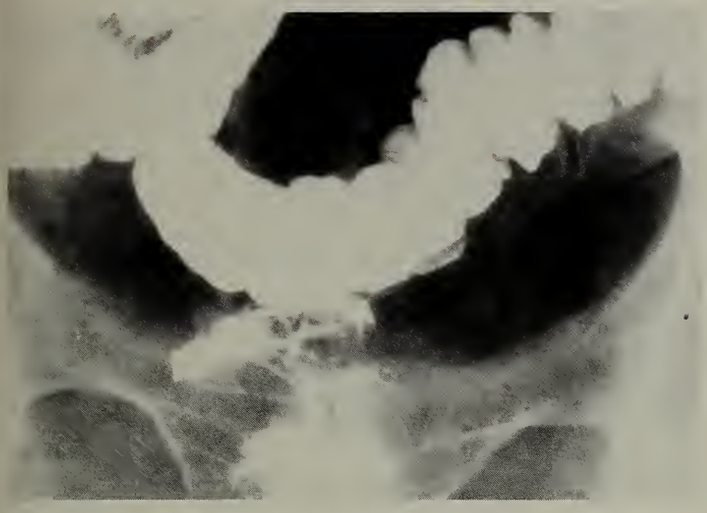


Figure 2

Poor distension of the rectosigmoid area precluded adequate visualization of a persistent filling defect along the right lateral rectal wall. An example of technical factor error.

Perceptual errors were defined as cases with obvious lesions that were not identified. This group included three cases. Figures 3, 4.

Interpretive errors, or distractions, were those cases with concomitant abnormalities of the colon, especially diverticula. There were two cases included in this group. These cases were inherently a measure of specificity, not sensitivity, but are included for completeness.

The last two cases revealed no visible abnormality retrospectively, even using the surgical location of the tumor as a guide for region of interest. The tumor areas in question were all well represented on spot and routine films, and could not be identified as abnormal by any of the staff retrospectively. This 25% "invisibility" is mid-range in the various reported values of non-visualized colonic cancers.[4,10,12,15]

The final observation concerns the tumor locations found in this study. Referring again to Table I, the preponderance of sigmoid locations is the most outstanding difference in these cases compared to previously cited studies. The remaining percentages tend to follow the pattern of increasing tendency to arise in proximal portions of the colon as compared to the statistics of 1978 or earlier.[5,6,17]

Summary and Conclusions

The pathology reports of all colonic neoplasms with barium enema examinations were reviewed with the pertinent radiographs to determine the false-negative interpretation rate at Aultman Hospital during one calendar year. There were 12 false-negative cases in 84 colonic neoplasms reviewed yielding a 14.3% false-negative rate. Nine of 64 single-contrast exams were misinterpreted, and three of 20 double-contrast exams were similarly falsely negative.

Four areas were considered to explain these interpretive errors. Perceptual errors accounted for three cases of false-negative interpretation. Interpretive errors (distractions) were identified in two cases; both were concomitant diverticulosis. Technical factors (inadequate mucosal coating with barium and rectal balloon obscuration of lesions) were most important and were responsible for five cases. The final two false-negative cases had no visible abnormalities despite technically adequate studies and good visualization of the colonic mucosa radiographically.

With 50% of the missed diagnoses located in the rectal area, the major question arising is how can this anatomic area be more successfully viewed. Digital rectal examination, better technique in obtaining air-contrast views of the rectum, avoiding rectal balloon inflation whenever possible, and improved surveillance when reading the enema radiographs are all feasible methods of increasing the sensitivity of this examination. If one accepts the concept that earlier detection of colonic carcinoma leads to improved survival statistics, and accepting the responsibility as radiologists for examination of the entire colon as advocated,[15] implementation of any or all measures to improve the sensitivity of an examination seems imperative.



Figure 3

A perceptual error example. Obvious anterior wall carcinoma seen in double contrast.

The selection of single- vs. double-contrast examination most often rests with the medical gastroenterologist, internist or family practitioner requesting the exam. The radiologists review the exam requisitions and will occasionally reschedule single-contrast cases as double-contrast studies dependent upon clinical risk factors and history. It is not cost- or time-effective to do all colon studies as double-contrast, and recognition of risk factors for colorectal cancer will help delineate patients needing double-contrast barium enemas.[17,20,21]



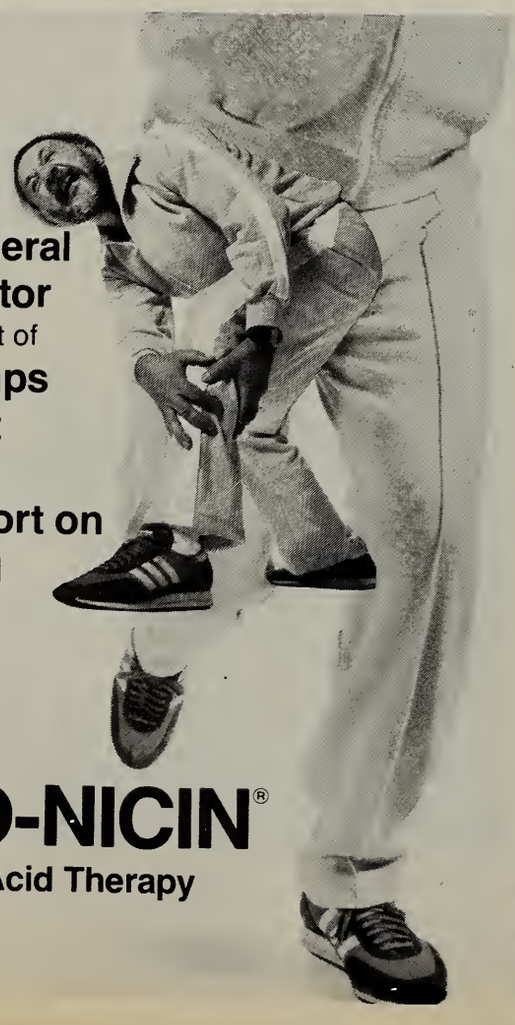
Figure 4

Two views of a lesion just proximal to the enema tip. This was not appreciated in the original interpretation.



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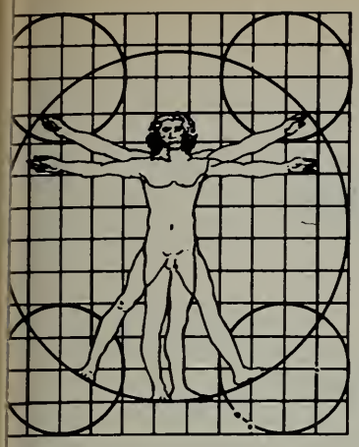
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INFECTIONS IN TOTAL JOINT REPLACEMENT

Ronald G. Hayter, MD
Thomas H. Mallory, MD, FACS

Total joint replacement is a generally successful procedure with high patient satisfaction and a relatively low rate of complications. Postoperative infection is the most serious complication, both medically and economically. This article is a review of several aspects of the problem of infected joint arthroplasty with particular attention directed to the primary care practitioner.

Infection is the most serious and dreaded complication of total joint replacement. Current estimates place the number of hip replacements at 250,000 per year throughout the world, with knee replacements probably a third as much. With the deep sepsis rate averaging 1-10%, it is clear there is a considerable problem. Lunceford has estimated the cost of an infected total joint prosthesis to be $75,000 to $150,000.[17] The morbidity and mortality rates are significant, with one large series reporting an overall death rate of almost 3% from either operation or the infection itself.[4]

Ideally, the risk of deep sepsis should be less than 1% if appropriate preventive measures are employed, a figure achieved by the originator of the operation, Sir John Charnley.[6] Prophylactic antibiotics and a clean-air operating environment are the major factors, but also included are careful screening of patients for possible foci of infection, shortened operating time, and possibly antibiotic-impregnated cement. The incidence of hip infections has been reported to be doubled if the patient has had a previous operation such as an osteotomy or internal fixation of a fracture.[7]

Etiology and Prophylaxis

Infection of total joint replacements may occur as a result of local seeding of organisms during surgery or hematogenous seeding from bacteria. Much attention has been directed to lessening the potential for local contamination during surgery by careful skin preparation, water-impermeable drapes, iodine-impregnated adherent plastic skin drapes, Laminar air-flow rooms, and body-isolator exhaust gowns.[16,18] Hematogenous dissemination as the result of bacteremia is more problematic, as it may occur from a variety of sources. Transient bacteremia may develop from any manipulation of the oral cavity, GI tract, or GU tract. Other possible sources are any local or systemic infection such as cholecystitis. A wide variety of species may be responsible for hematogenous seeding, depending on the manipulation that has been performed or the type of primary infection which has been associated with the bacteremia.

Complete protection against late hematogenous seeding is not feasible, yet emphasis must be placed on protecting the patient during times of risk. Many different diagnostic and therapeutic interventions may be associated with transient bacteremia including dental manipulations, urologic procedures, liver and kidney biopsies, and gastrointestinal procedures such as upper or lower endoscopy and even barium enema. The bacteremia is transient and the number of organisms present in the blood is probably low, although the number required to produce an infected joint replacement is not known.[10,21] In view of the devastating consequences of infection, the potential benefits of prophylaxis far outweigh the possible risks associated with antibiotics. A similar situation exists in patients who have had cardiac valves implanted, where prophylaxis has been widely accepted. The choice of a particular antibiotic would depend to some degree on the type of procedure and the organisms most likely prevalent in the area to be manipulated. In the mouth or upper GI tract, streptococci are the most common bacteria to be found. Lower GI instrumentation is associated with bacteremia of aerobic Gram negatives, enterococci, or occasionally anaerobic Gram negatives. Genitourinary manipulation may result in aerobic Gram negative and enterococci entering the bloodstream; these same organisms may originate from a biliary tract foci.

Different microorganisms may be responsible for infection, with *staphylococcus aureus* and *staphylococcus epidermidis* accounting for approximately 60%, reflecting the probability of local contamination from the skin. Since local contamination occurs at surgery and/or is spread from contiguous sites, perioperative prophylactic antibiotics directed toward staphylococcus and, to a lesser extent, aerobic Gram negatives should be administered prior to surgery and for 24 to 48 hours thereafter.

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The value of this regime has been proven by a very considerable reduction in the rate of sepsis in several reported series.[6,8] Debate has centered on the most appropriate antibiotic for prophylaxis, taking into consideration cost as well as effectiveness. A broad-spectrum antibiotic such as a first generation cephalosporin, which is active against both Gram positive and Gram negative bacteria, would appear to be a reasonable choice. An example would be cefazolin, which has a long half-life, is well tolerated even in some cases of penicillin allergy, and is moderately inexpensive.

Antibiotic Selection

Oral penicillin would be suitable for streptococci, although intramuscular procaine penicillin gives higher serum levels in a shorter time. Oral cephalosporins are appropriate for those allergic to penicillin (with a history of nonanaphylactic response) or intramuscular vancomycin. Aerobic and anaerobic Gram negatives are more problematic. Intramuscular or intravenous aminoglycocides are the drug of choice, but present a problem for widespread use as prophylactic agents. Oral clindamycin is an acceptable alternative.

Diagnosis

Treatment of an established deep infection of a total joint replacement is time-consuming, expensive, and fraught with danger for the patient. The diagnosis is often difficult, and frequently established only with surgery.[15] A recent study by Cherney and Amstutz[7] found no statistically significant difference between infected and noninfected hip replacements with regard to complete blood count with differential or erythrocyte sedimentation rate. They also pointed out the difficulty of relying on joint aspiration and arthrography, which has a high false positive and false negative rate. Radionuclide scanning has been of benefit, particularly when combining technetium and gallium scanning.[9] Indium scanning has been proposed to be of more value, but is still in the early stages of development. Cultures and examination of material obtained at surgery are more accurate than those from preoperative aspirations, but, even so, both false positives and false negatives have been reported.[1,12,14] Plain radiographs are frequently the most helpful in terms of evaluating an arthroplasty for infection.[2] A joint with an acute infection will usually have normal appearing x-rays, unless there is pre-existing mechanical loosening. A radiograph that shows signs of failure may have subacute sepsis that will require intraoperative cultures to make a definitive diagnosis. An arthroplasty with established sepsis will usually show extensive osteolysis, more than one would expect with simple mechanical loosening, and there may also be signs of osteomyelitis such as periosteal elevation and cortical scalloping. (Fig. 1)

Treatment

The options for management of an established infection include: 1) antibiotic suppression, 2) surgical debridement leaving the prosthesis *in situ,* 3) removal of the prosthesis and cement, 4) exchange arthroplasty — either immediate or delayed, 5) removal of the prosthesis and arthrodesis, and 6) amputation. For an elderly or medically frail patient, prolonged antibiotic suppression may be the treatment of choice, realizing that antibiotics alone will not eradicate the infection. If this method is to be successful, the organism should be of low virulence, the patient must be able to tolerate long-term antibiotics, and the prosthesis must be mechanically sound.

Infrequently, surgical debridement and intravenous antibiotics may salvage a joint replacement. This technique is most applicable in acute infections when treatment is begun shortly after the onset, and the prosthesis is well-fixed.[19]

Removal of all prosthetic components and cement, leaving the patient with a flail joint, has been reported to be satisfactory in several series, although the functional results are certainly not as good as a sound total joint.[3,22] Frequently, the patient will require some type of brace or aid for ambulation. Infection with Gram negative or anaerobic bacteria would influence the surgeon toward this method, as would a draining sinus or severe bone loss.

Exchange arthroplasty, either immediate or delayed, has recently gained favor based on the encouraging success reported by Buchholz and others.[4,13] This is a demanding technique, with radical debridement absolutely necessary so that at the conclusion of the procedure the wound appears fresh and uncontaminated. Antibiotic impregnated cement appears to favorably influence the results.[5,20] Immediate reimplantation is most appropriate for the patient with good bone stock and infection of low virulence that is highly susceptible to antibiotic. Delayed reimplantation seems to be preferred by most surgeons in the United States, and may be more predictable.[13,22] In this technique, radical surgical debridement of all infected or devitalized tissue and bone is performed, followed by primary or secondary wound closure. This is followed by a prolonged course of antibiotics, ranging from three weeks to one year. If the wound is healed without evidence of recurrence of the infection, reimplantation of the prosthesis is performed, with another course of antibiotics for varying time periods, preferably three to six months.

Arthrodesis as a technique for salvage of an infected prosthesis is most frequently performed at the knee, since the functional results are better and more reliable than at the hip.[3,11] It should be considered especially in younger patients. Fusion may be difficult to achieve and often requires special techniques including external fixation, and is not indicated for patients with contralateral arthritic joints.

Amputation is rarely required and should be reserved for patients with uncontrollable, life-threatening sepsis, or for those with massive bone loss that is not amenable to other techniques of salvage.



Figure 1
Radiograph showing changes of infected arthroplasty. Upper left arrow indicates cortical scalloping and osteolysis. Upper right arrow indicates endosteal cortical scalloping. Lower right arrow indicates periosteal elevation.

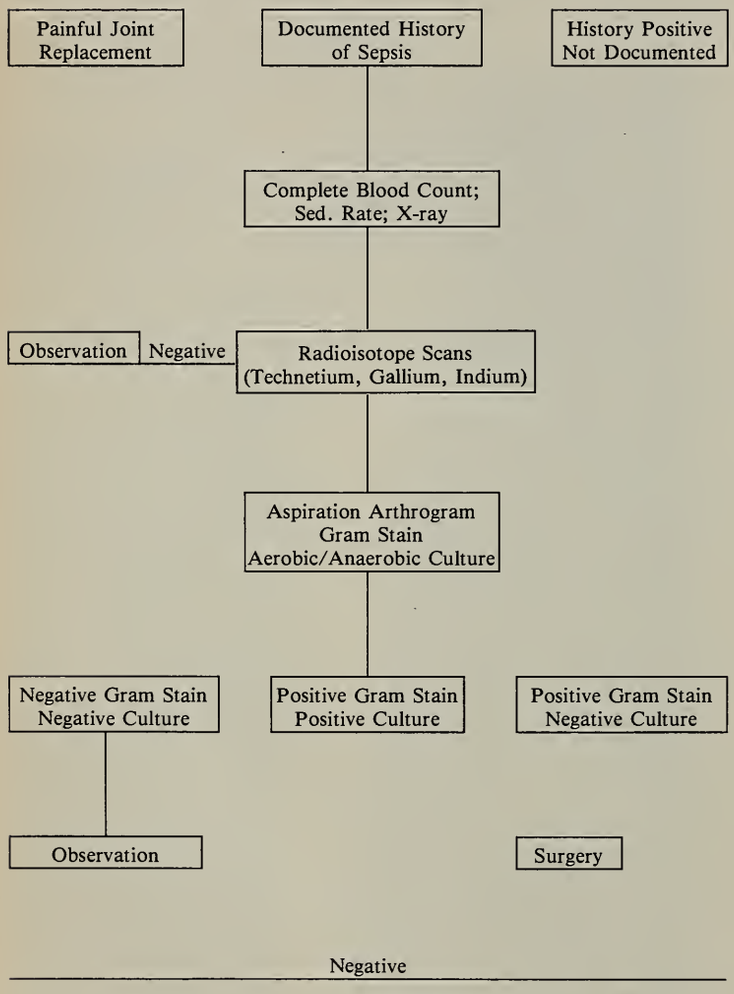
Suggestions for Primary Care Physicians

Frequently a patient in the early stages of infection of a total joint replacement will seek treatment from his or her primary medical practitioner. Not all of these patients will have obvious signs of infection, so that a high index of suspicion is required. Obviously, a joint that is acutely inflamed, tender, and with a painful restricted range of motion needs to be quickly evaluated and referred for treatment to the appropriate specialist. Also, there is not much doubt regarding the patient with a draining sinus. The problem lies in the patient with poorly defined symptoms and some loss of function. Most often, a patient with an infected joint will have constant pain unrelieved by rest, as opposed to a patient with mechanical failure whose pain is usually relieved by restriction of activities or use of ambulatory aids.

Early management of a possibly infected joint replacement includes screening blood work, careful examination of the wound and involved joint, and referral for further diagnostic evaluation. Treatment with oral antibiotics alone is to be condemned, as it may lead to either partial suppression or, worst of all, creation of antibiotic resistance of the organism involved, or superinfection that would greatly reduce the chances of a successful outcome.

A delay in treatment of days to weeks may negatively influence the chances of successful eradication of infection. Persistent sepsis of a total joint arthroplasty may spread to the surrounding bone with the resultant osteomyelitis producing further bone loss as well as making it more difficult to cure the infection.

EVALUATION FOR SEPTIC ARTHROPLASTY



Conclusion

Infection of a total joint replacement is a complex problem requiring much time and expense on the part of both patient and surgeon. Newer techniques are promising, but not all joints are salvageable. Greater interest and knowledge on the part of the primary medical practitioner would be helpful in instituting prompt, appropriate management of this difficult situation.

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continued on page 124

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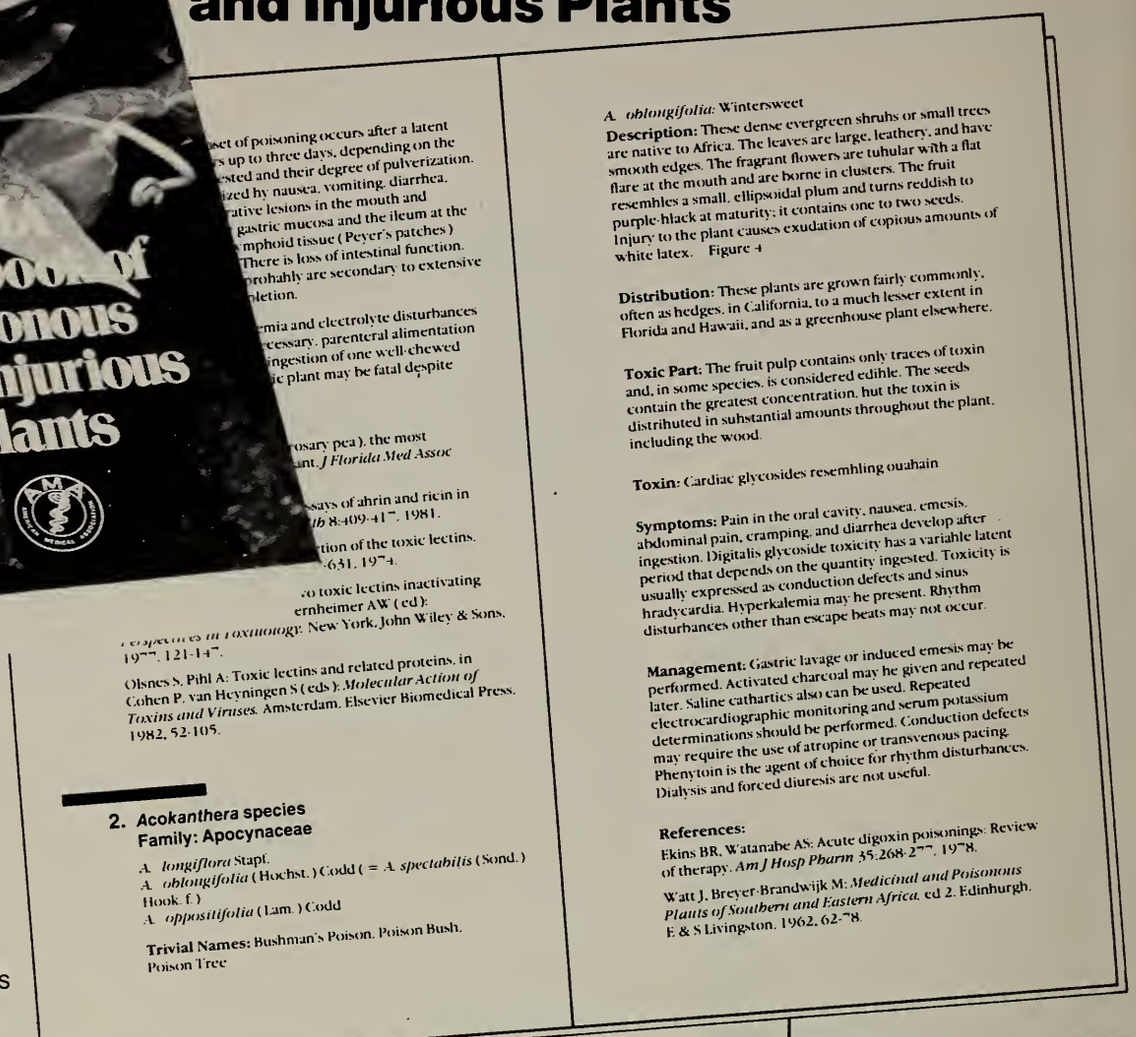
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...tion of the toxic lectins. ...631, 1974.

...o toxic lectins inactivating ...ernheimer AW (ed): ...*Perspectives in Toxinology*. New York, John Wiley & Sons, 1977, 121-147.

Olsnes S, Pihl A: Toxic lectins and related proteins, in Cohen P, van Heyningen S (eds): *Molecular Action of Toxins and Viruses*. Amsterdam, Elsevier Biomedical Press, 1982, 52-105.

2. *Acokanthera* species
Family: Apocynaceae

A. longiflora Stapf.
A. oblongifolia (Hochst.) Codd (= *A. spectabilis* (Sond.) Hook. f.)
A. oppositifolia (Lam.) Codd

Trivial Names: Bushman's Poison, Poison Bush, Poison Tree

A. oblongifolia: Wintersweet

Description: These dense evergreen shrubs or small trees are native to Africa. The leaves are large, leathery, and have smooth edges. The fragrant flowers are tubular with a flat flare at the mouth and are borne in clusters. The fruit resembles a small, ellipsoidal plum and turns reddish to purple-black at maturity; it contains one to two seeds. Injury to the plant causes exudation of copious amounts of white latex. Figure 4

Distribution: These plants are grown fairly commonly, often as hedges, in California, to a much lesser extent in Florida and Hawaii, and as a greenhouse plant elsewhere.

Toxic Part: The fruit pulp contains only traces of toxin and, in some species, is considered edible. The seeds contain the greatest concentration, but the toxin is distributed in substantial amounts throughout the plant, including the wood.

Toxin: Cardiac glycosides resembling ouabain

Symptoms: Pain in the oral cavity, nausea, emesis, abdominal pain, cramping, and diarrhea develop after ingestion. Digitalis glycoside toxicity has a variable latent period that depends on the quantity ingested. Toxicity is usually expressed as conduction defects and sinus bradycardia. Hyperkalemia may be present. Rhythm disturbances other than escape beats may not occur.

Management: Gastric lavage or induced emesis may be performed. Activated charcoal may be given and repeated later. Saline cathartics also can be used. Repeated electrocardiographic monitoring and serum potassium determinations should be performed. Conduction defects may require the use of atropine or transvenous pacing. Phenytoin is the agent of choice for rhythm disturbances. Dialysis and forced diuresis are not useful.

References:
Ekins BR, Watanabe AS: Acute digoxin poisonings: Review of therapy. *Am J Hosp Pharm* 35:268-277, 1978.

Watt J, Breyer-Brandwijk M: *Medicinal and Poisonous Plants of Southern and Eastern Africa*, ed 2. Edinburgh, E & S Livingston, 1962, 62-78.

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Colleagues In The News

Edited by Deborah Athy

AL BATATA, MD, director of Wright State Lymphology Research Laboratory, has been appointed chair of the School of Medicine's Department of Pathology.

RONALD B. BERGGREN, MD, Columbus, has been elected president-elect of the Plastic Surgery Educational Foundation.

JOSEPH P. BURICK, DO, a pediatrician at Children's Hospital Medical Center of Akron, has been appointed to the Board of Directors of the Summit County Health Board.

JAE C. CHANG, MD, Dayton, director of oncology at Good Samaritan Hospital, has received the Wright State Academy of Medicine's Professional Excellence Award for his service as a voluntary professor at Wright State's School of Medicine.

LIBERATO J.A. DIDIO, MD, DSc, PhD, Toledo, has been selected secretary general of the International Federation of Associations of Anatomists. Dr. DiDio is a professor and the founding chairman of the graduate school at the Medical College of Toledo.

JAMES W. FERRARO, DDS, MD, Columbus, has been elected assistant treasurer of the American Society of Maxillofacial Surgeons.

RICHARD J. FLAKSMAN, MD, co-director of the Neonatal Intensive Care Unit at Children's Hospital Medical Center of Akron, has been appointed co-director of the Akron Regional Perinatal Center.

ARNOLD FRIEDMAN, MD, of Mt. Sinai Hospital in Cleveland, was elected alternate chairman of the Ohio Chapter of the American Academy of Pediatrics.

JOSEPH FROLKIS, MD, of Mt. Sinai Hospital in Cleveland, has been invited to serve on a special task force on "Defining the General Internist." The task force is sponsored by the Advisory Group of the Society for Research and Education in Primary Internal Medicine.

WILLIAM GATES, MD, former president of the Cincinnati Academy of Medicine and chairman of its emergency medical services committee, has received the 1985 Public Safety Leadership Award in recognition for his outstanding leadership in helping to bring about the 911 emergency telephone service.

MICHAEL JEROME GELFAND, MD, assistant professor of pediatrics and associate professor of radiology; **MYRON GERSON, MD,** assistant professor of medicine and radiology; and **JAMES WOOD, JR, MD,** director of obstetrics, all of the University of Cincinnati Medical Center, recently received research grants from the Southwestern Ohio Chapter of the American Heart Association.

SAUL GENUTH, MD, of Mt. Sinai Hospital in Cleveland, has received the 1985 Maurice Saltzman Award for his contributions in diabetes research and treatment.

JOSEPH E. GHORY, MD, Cincinnati, has received the first Daniel Drake Humanitarian Award for exemplifying traditional humanitarian values in medicine.

MICHAEL G. GRESSEL, MD, Lorain, has been named an investigator in the Fluorouracil and Glaucoma Filtering Surgery National Collaborative Study sponsored by the National Eye Institute.

MAX GRIFFIN, MD, Akron, Director of Ambulatory Pediatric Medicine, has received the Pediatric Recognition Award for Outstanding Contributions to Health and Welfare of Children in Ohio.

JAMES GOLDFARB, MD, of Mt. Sinai Hospital in Cleveland, has been elected a charter member of the Society of Reproductive Surgeons.

JULIAN GORDON, MD, of Mt. Sinai Hospital in Cleveland, has been elected a Fellow of the American College of Surgeons.

JOHN J. HALKI, PhD, MD, associate professor and chairman of obstetrics and gynecology at Wright State, has been appointed to the first Nicholas J. Thompson Distinguished Professorship of the Wright State School of Medicine Department of Obstetrics and Gynecology.

PETER K. LAUF, MD, Dayton, has been appointed director of the School of Medicine Physiology and Biophysics Program at Wright State University.

MARK LEVINE, MD, of Mt. Sinai Hospital in Cleveland, has been elected president of the American Society of Ophthalmic Plastic and Reconstructive Surgeons; has been appointed to the Board of Chancellors of the American Academy of Ophthalmology; and has been elected president of the Cleveland Ophthalmological Society for 1985-1986.

MILTON LINDEN, MD, Cleveland, has received the Mt. Sinai's Julius E. Goodman Award for 1985. Dr. Linden is the Emeritus Director of the Department of Obstetrics and Gynecology at Mt. Sinai.

JOHN MARTIN, MD, Toledo, professor and chairman of anesthesiology at the Medical College of Ohio, has been re-elected to the Board of Trustees of the International Anesthesia Research Society.

THOMAS C. NAMEY, MD, of the Medical College of Ohio in Toledo, has been appointed to membership on the U.S. Power Lifting Federation, where he will coordinate medicine and scientific information during international power lifting competitions.

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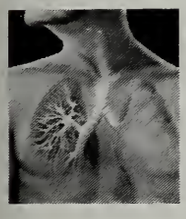
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Enterobacter spp.
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In acute otitis media in children

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Streptococcus pneumoniae
Haemophilus influenzae
(even ampicillin-resistant strains)



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Clears the sputum of important susceptible pathogens:

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CONTRAINDICATIONS: Hypersensitivity to trimethoprim or sulfonamides; documented megaloblastic anemia due to folate deficiency; pregnancy at term and during the nursing period; infants less than two months of age.

WARNINGS: FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently.

BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS:

General: Give with caution to patients with impaired renal or hepatic function, possible folate deficiency and severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur, frequently dose-related.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently; if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffé alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenesis: Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. *Mutagenesis:* Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. *Impairment of Fertility:* No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folic acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS and CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).** *Hematologic:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, methemoglobinemia, eosinophilia. *Allergic Reactions:* Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. Periarteritis nodosa and systemic lupus erythematosus have been reported. *Gastrointestinal:* Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. *Genitourinary:* Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. *Neurologic:* Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. *Psychiatric:* Hallucinations, depression, apathy, nervousness. *Endocrine:* Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. *Musculoskeletal:* Arthralgia, myalgia. *Miscellaneous:* Weakness, fatigue, insomnia.

DOSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN: *Usual adult dosage* for urinary tract infections is one DS tablet, two tablets or four teaspoonfuls (20 ml) *b.i.d.* for 10 to 14 days. Use identical daily dosage for 5 days for shigellosis. *Recommended dosage for children* with urinary tract infections or acute otitis media is 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses every 12 hours for 10 days. Use identical daily dosage for 5 days for shigellosis. *Renal Impaired:* Creatinine clearance above 30 ml/min, give usual dosage; 15-30 ml/min, give one-half the usual regimen; below 15 ml/min, use not recommended.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS: Usual adult dosage is one DS tablet, two tablets or four teasp. (20 ml) *b.i.d.* for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS: Recommended dosage is 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

HOW SUPPLIED: *DS (double strength) Tablets* (160 mg trimethoprim and 800 mg sulfamethoxazole—bottles of 100, 250 and 500; Tel-E-Dose* packages of 100; Prescription Paks of 20. *Tablets* (80 mg trimethoprim and 400 mg sulfamethoxazole)—bottles of 100 and 500; Tel-E-Dose* packages of 100; Prescription Paks of 40. *Pediatric Suspension* (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 100 ml and 16 oz (1 pint). *Suspension* (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 16 oz (1 pint).

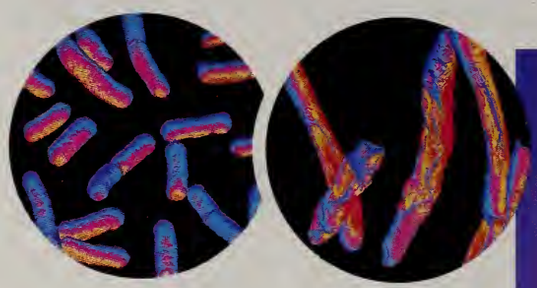
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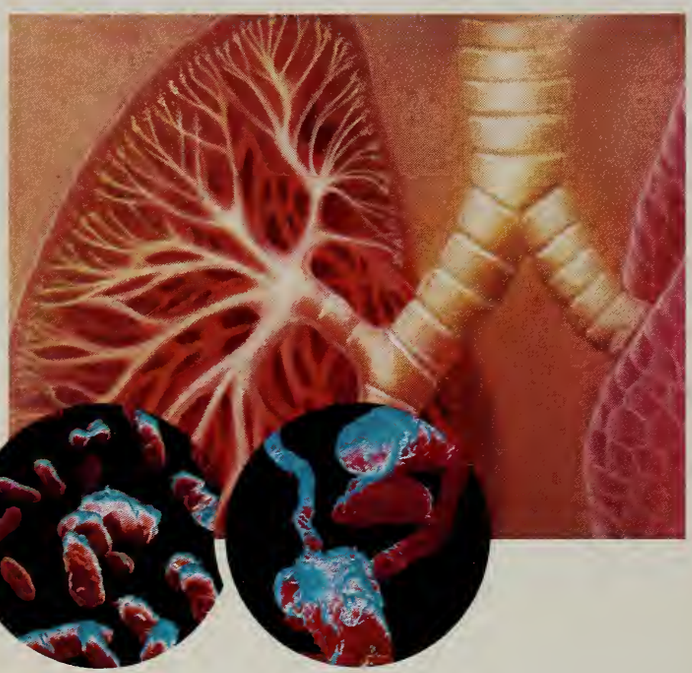
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before Otoscopic view of tympanic membrane in a patient who did not respond to ampicillin therapy.

after Same patient after ten days of Bactrim therapy.

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acute exacerbations of chronic bronchitis
and acute otitis media

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Please see preceding page for a summary of product information.

THE Ohio STATE Medical Journal

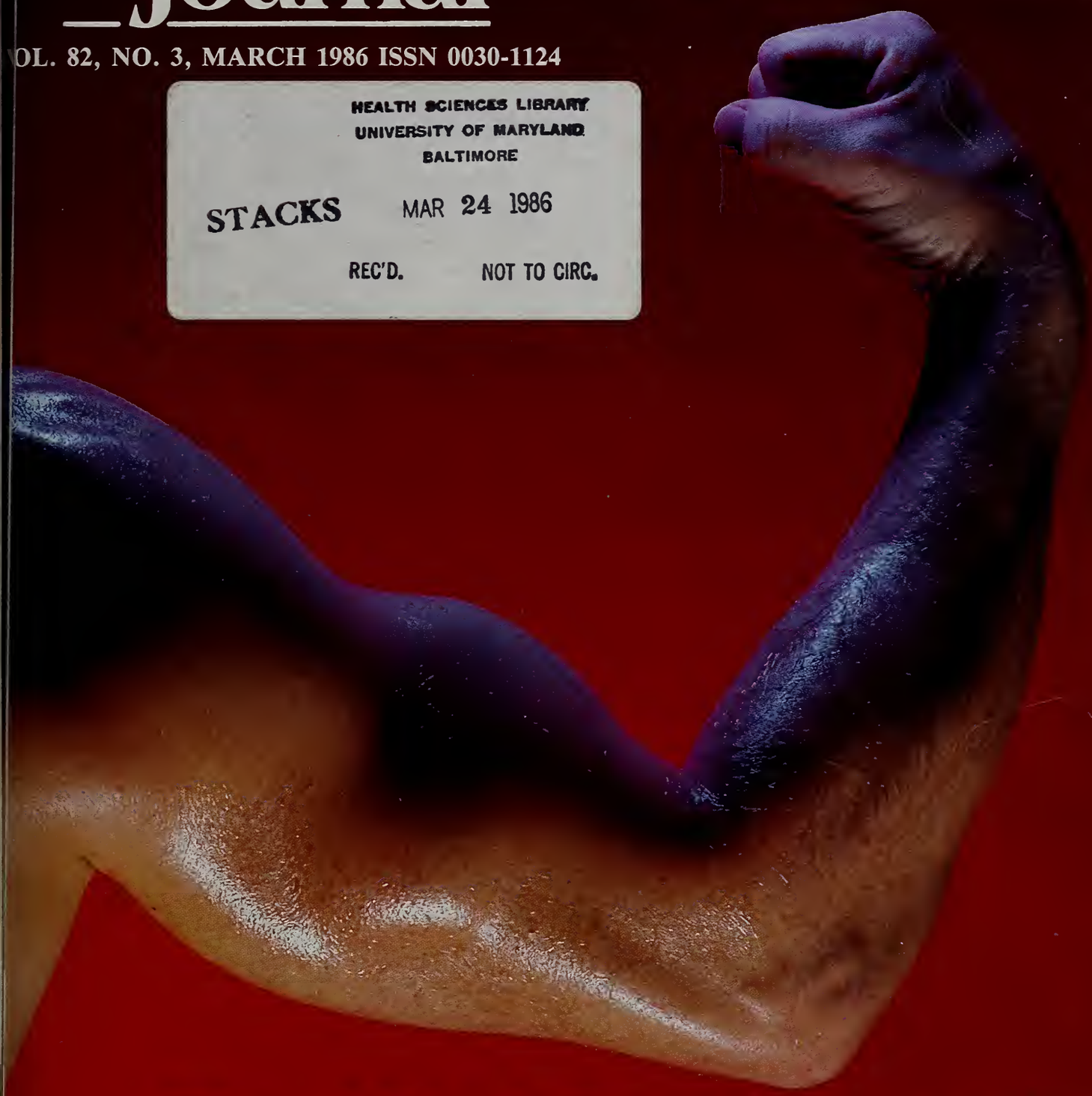
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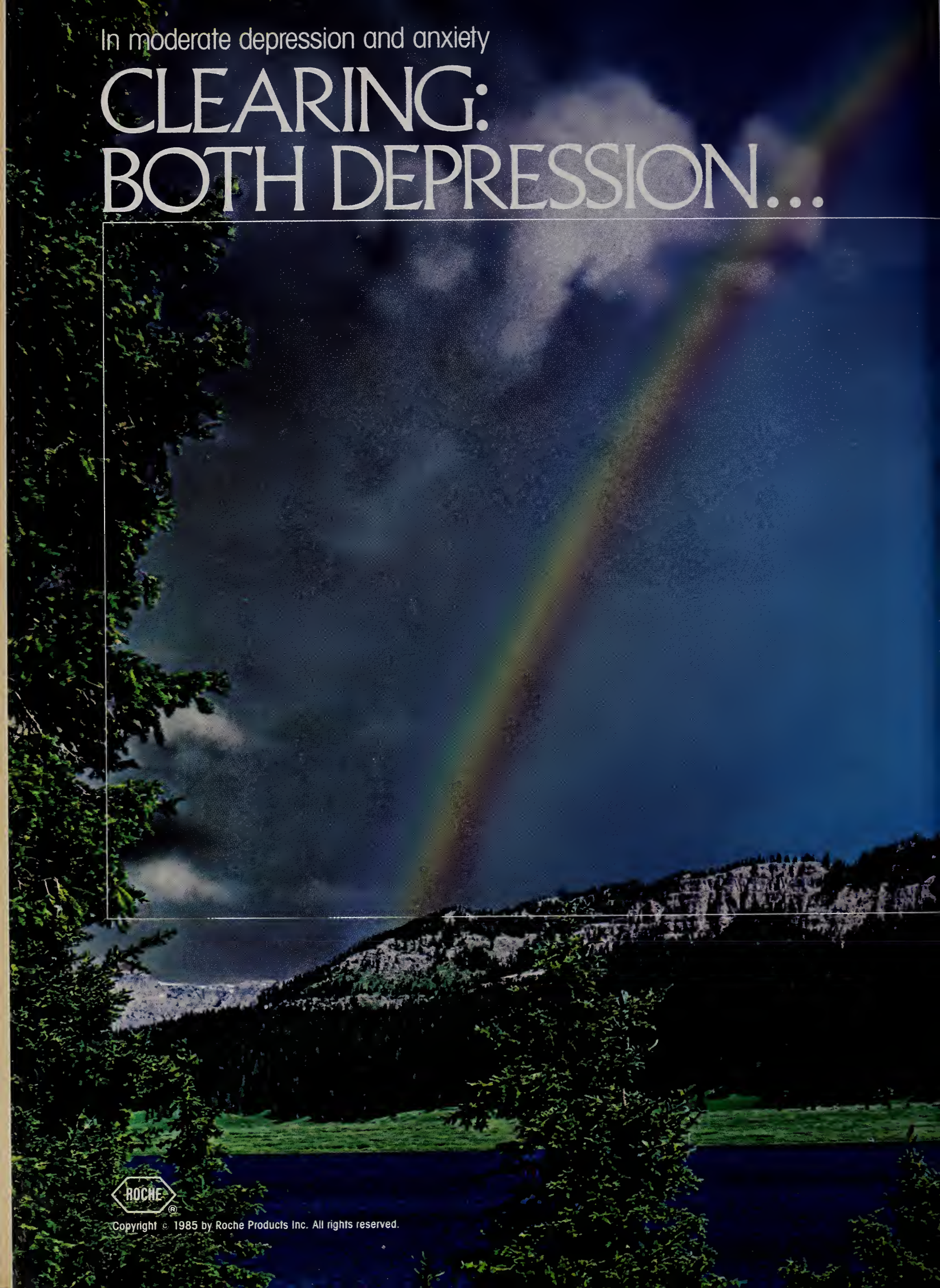


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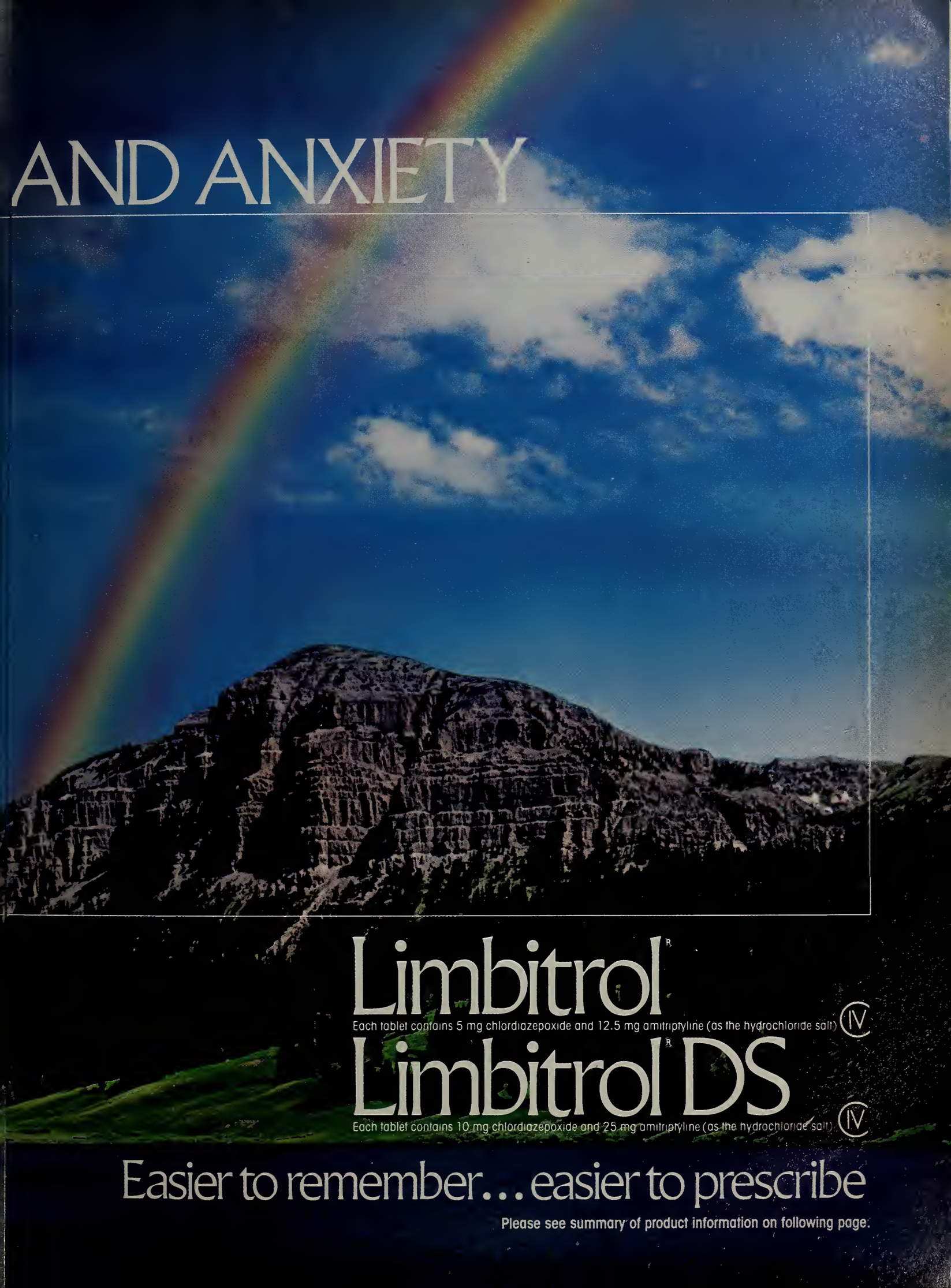
In moderate depression and anxiety

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Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.
Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: *Double strength (DS) Tablets*, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets*, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescriptian Paks of 50.

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Herman I. Abromowitz, MD

Physicians Can Make A Difference

Recently, Xenia, Ohio passed a law which, indeed, makes me very proud of my hometown. Xenia has virtually banned smoking in all public areas.

All who know me realize that — besides being an ardent Buckeye — I am very adamant and outspoken on the subject of cigarette smoking. It is in my opinion a dreadful and harmful habit which will ultimately *rob* a person of health. Worse yet, it affects everyone, even those who choose not to smoke. That's why I am so pleased that Xenia has taken such a strong stand against smoking.

But, as proud as I am of my hometown, I am even prouder of Ohio physicians for taking the lead against cigarette advertising on a national level.

At the 1985 OSMA Annual Meeting in May, 1985, the House of Delegates approved Resolution 44-85 which calls for a prohibition against media advertising of tobacco products. This resolution was originally introduced by Konrad Kircher, MD, and was sponsored by the Montgomery County Medical Society. This resolution was enthusiastically approved by the OSMA House of Delegates, and subsequently submitted and approved by the AMA House of Delegates at the Interim Meeting in December, 1985.

This is not the first time organized medicine has taken a stand against smoking. Through the years, this health hazard has been examined and discussed at almost all levels of medicine. Most recently, at the AMA's Leadership Conference, medicine's commitment to this cause was repeatedly stressed.

In Ohio we are being joined in the fight by the OSMA Auxiliary, which plans to make a campaign against the use of smokeless tobacco one of its top priorities.

All of this attention on the issue of smoking and the use of smokeless products has spawned a large number of bills at the Ohio Statehouse concerning this subject. Presently there are bills pending which range from calling for the prohibition of smoking in places of public assembly to increasing the state cigarette tax by 5 cents per pack to fund cancer research and treatment.

Our elected leaders are looking to the medical profession for help in deciding these issues and I think it is essential that we give them this assistance. The OSMA Legislative Committee, under the Chairmanship of William J. Marshall, MD, and the OSMA Legislative staff, under the direction of Rick Ayish, are working to provide assistance and support on this legislation.

Cigarette smoking has unfortunately become such an acceptable lifestyle habit by many throughout the world that it may seem inconceivable that any group — physicians included — could have hope of influencing a lifestyle change.

But it can and must be done. As physicians we can indeed make a difference. We must lead the way.

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1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted *in the original* on standard 22 x 28-cm (8½ x 11-inch) white typing paper.
(b). A copy of the manuscript should be retained by the Author.
(c). *The entire text including lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.*
(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. *The Journal* will assume $10 of this expense and the author will be billed by *The Journal* for the remainder.
(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.
(c). Legends for the figures should be written on separate paper.
(d). The author must affirm that he has *written releases* on all photographs in which patients can be identified.

5. **ABSTRACTS.** A *short* (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.
(b). References should be listed in the *order of their appearance in the text.*
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"2. Doe J, Roe RX: How to go about it. Ohio State MJ 13:24-30, 1920"
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8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should *not* be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections and to have the manuscript retyped. Any changes, other than typographical errors, made by the Author after the manuscript is set in type will be billed to him at $2 per line.

11. **REPRINTS.** An order blank for reprints with a table covering cost will be sent with the galley proofs to the Senior Author. *The Journal* does not profit on reprint orders.

12. **EDITORIAL ASSISTANCE.** Ms. Deborah Athy, Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Relationships . . . Past, Present and Future

First, there were doctors.

Then, there were doctors and nurses and pharmacists.

Then, there were doctors and nurses and pharmacists — and podiatrists and chiropractors and optometrists and psychologists.

Then, the nurses began to spawn specialists; so, in addition to all of the above, nurse-anesthetists, nurse-midwives and nurse-practitioners were added to the lengthening list of health-care professionals.

And still the list grows.

Now, medical assistants, physician assistants and others with more technical names have been added to the ranks, so that, anymore, a patient may be hard-pressed to tell you *who* is taking care of *what*.

And the patient isn't the only one.

As the traditional roles of doctors and nurses begin to blur and merge, divide and subdivide, it's no wonder that feelings of confusion and unrest are raised. Professional lines are being redrawn, and "old turf" is falling away under the shovels of a whole new array of ground-breakers. Naturally, there are tensions and disagreements.

This month, the *Journal* takes a look at the "health care" pie and at all of those providers who are eager for a piece of it.

Our cover story, by Associate Editor Susan Porter, takes an historical look at interprofessional relationships, how and why they're merging, and how we can expect these relationships to shape up in the future.

Following that is an article which examines these merging relationships in a more positive way. Interprofessional councils, hospital units and teaching curriculums are growing in number — proof positive, they say, that all health-care deliverers *can* and *should* work as a team.

As the traditional roles of doctors and nurses begin to blur and merge, it's no wonder that feelings of confusion are raised . . .

In unrelated matters this month, our "Councilor Commentary" is back this time with views from the Third and Twelfth Districts (Thomas R. Leech, MD, and Joseph L. Kloss, MD, respectively).

And look for the latest AMA business in an article by Oscar Clarke, MD, Chairman of the Ohio Delegation to the AMA, and OSMA President Herman I. Abromowitz, MD. Their report of the action taken at the AMA's interim business meeting last December will keep you abreast of medicine's current concerns.

And for medicine's current *events,* don't miss the "Ohio Medi-scene" section this month. In addition to providing you with updated information on some past stories we've published, it also gives you a look at a new drug being tested for the treatment of heart disease, and the latest research being conducted here in the state.

Next month, we'll be bringing you the Annual Meeting program issue. If you haven't yet registered for the OSMA Annual Meeting — in Dayton this year — you'll want to look for the reservation form inside. Fill it out and send it in as soon as possible. Whether or not interprofessional relationships will be discussed, it's bound to be an interesting meeting — and one you won't want to miss. — *Karen S. Edwards*

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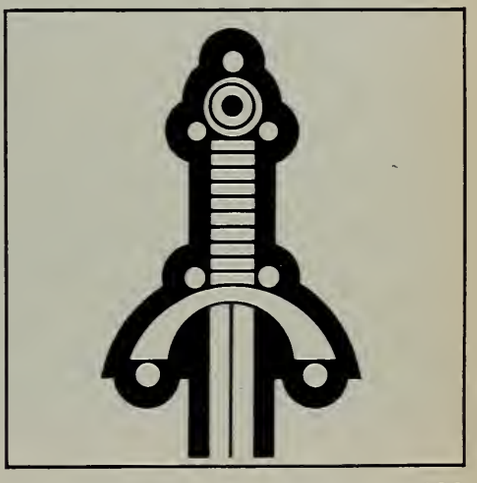
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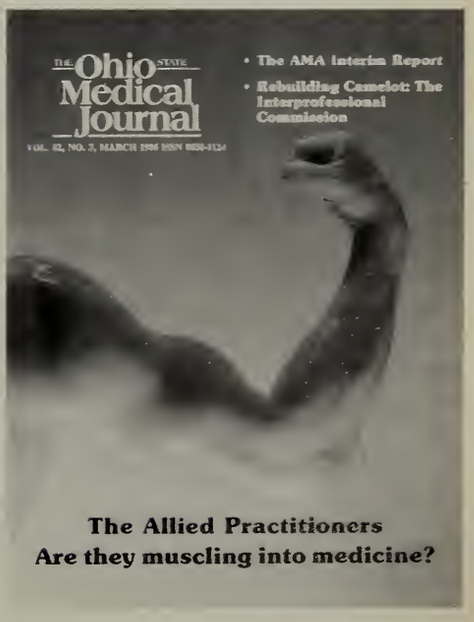
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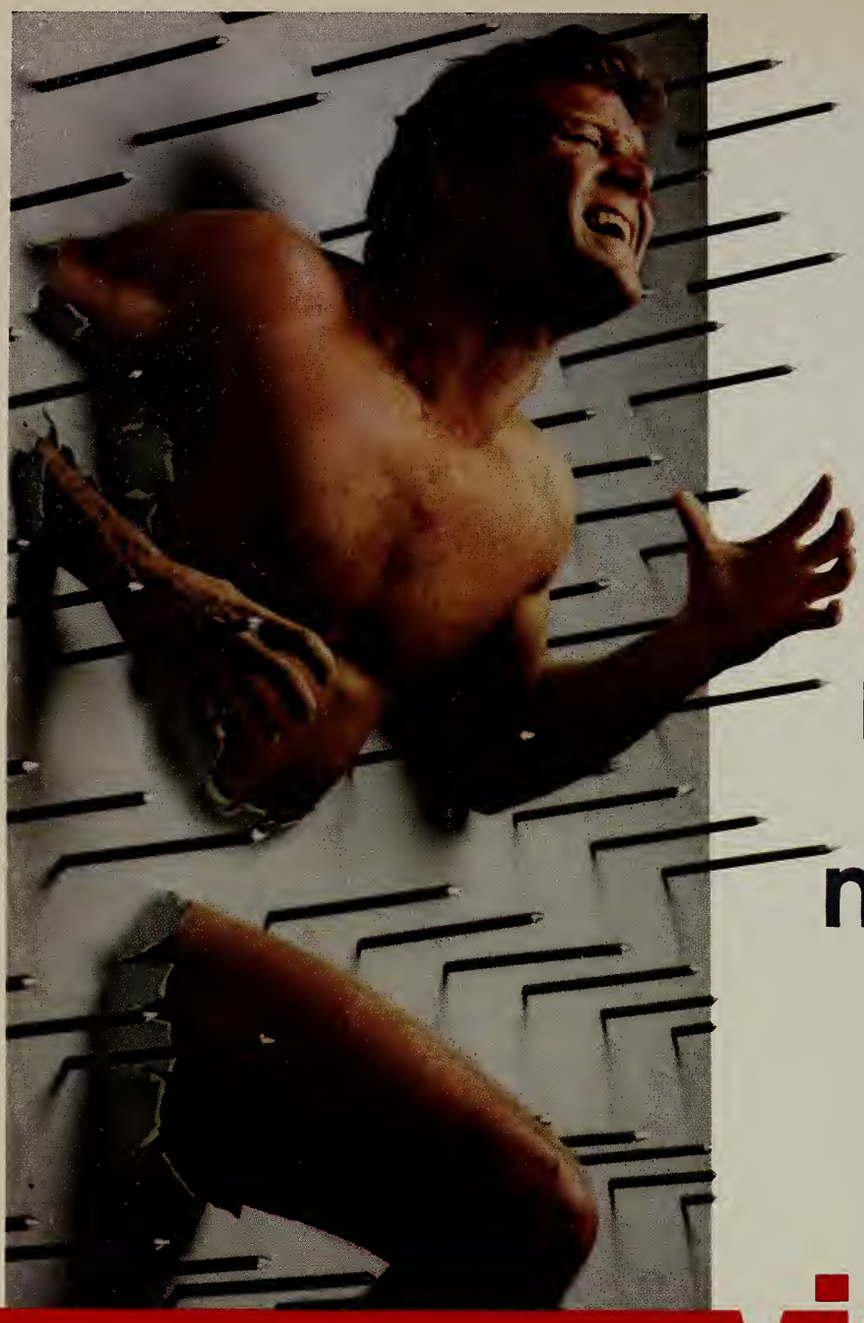
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The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982.

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February, 1985

Second Opinion

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of the Ohio State Medical Journal or the Ohio State Medical Association.

Someplace to Go

By Ralph Fried, MD

It appears to be grossly incongruous to refer to service in the Armed Forces of the U.S.A. as one of the country's most successful social programs for young people. As a pediatrician, I stand, as do all my colleagues, as an advocate for children. We are concerned not only for their physical well-being but also for their innate right to grow into their full potential as human beings and citizens of this country. Although we live in a democracy, not every one has the equal opportunity to achieve his best.

There are many social factors that affect children adversely — disruption of the family structure through divorce, unemployment, poverty and illness. Religious, racial and ethnic bias are still present and retard growth and development. Almost no one can progress without a good education, and the appalling truth is that in any big city school system one-third of the pupils are truant on any given day. An indeterminate group of youngsters are physically present in school but do not partake in the learning process. Uneducated adults can only work at menial jobs with minimum pay, and they soon are a community burden using such services as government assisted living, health care, and, worst of all, enmeshed in the criminal justice system.

Once I had withdrawn from working in my office, I began to work at the Cleveland Military Entrance and Processing Station (MEPS). This station is one of sixty nationwide and the fourth or fifth busiest. All applicants are volunteers; they come from all of Northern Ohio, from Youngstown to Toledo. The applicants are thoroughly interviewed and examined and receive laboratory tests, i.e. chest X-rays, urine, serology, hearing and vision screening and pregnancy tests for female applicants. If the examining physician detects any defects about which he is uncertain, he has the privilege of having a consultation, and he chooses from a panel of well regarded specialists in the area, from allergy to psychiatry. This is important because if someone is sworn in who is unfit for service, it is quite expensive to separate him at the level of the Boot Camp. The result is an in depth interview and a thorough physical, and the percentage of misfits is small.

Equally impressive is the concern shown for the welfare of the young volunteers. The out-of-town applicants are housed at local motels overnight. When they appear at MEPS, they receive a questionnaire that inquires about their accommodations, the food and the attitude of the motel employees. This is a refreshing change in attitude from what often happens in government contracts where there is minimum service for maximum cost. If the inductees complain, the hostelry can lose its contract.

The applicants also receive respectful treatment from the MEPS personnel, both from the infra-structure techs, the officers and the doctors. As an example, when the males are stripped to their shorts for the orthopedic exercises, it is not uncommon for one or more to be too poor to afford underwear. They are supplied with paper disposable boxer shorts. Female applicants are afforded even more privacy both for the orthopedic exam and the gynecology exam. They are carefully draped, the physicians have a sensitive attitude, and, of course, a female technician is always present.

continued on page 151



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Because Harmarville will pick him up. Our Occupational Health and Rehabilitation Services program (OHRS) works solely on getting good people, like Bob Seaman, with industrial injuries back on the job.

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HARMARVILLE

"High school graduates living in small towns perceived few economic opportunities. They had no money for college so military service was 'someplace to go.' "

MEPS is responsible for examining for the Army, Navy, Air Force and Marines. The reasons for volunteering are quite varied, interesting and informative. Some inductees have a record of prior service. They are re-enlisting because they found civilian life less desirable or they preferred the military and the security therein and chose to make it a career. Many had experienced lay-offs, especially in the smoke stack industries of this area; they rejected the welfare system and preferred the regular check from the U.S. Treasury. In the recession year of 1982 we noted a surge of applicants from areas such as Youngstown and Toledo. Another quota consists of high school drop-outs. These young people either regretted their immature impulse or they had learned that the economic system demanded either a high school diploma or a G.E.D. for meaningful employment. Also, there were a large number of bright, eager and ambitious youngsters who were anxious to have a higher education and perceived the Armed Forces as a pathway to that goal (more on this later). High school graduates living in small towns and rural communities perceived few economic opportunities where they lived. They had no money for college, so military service was "someplace to go."

A smaller number were attracted by the zest for adventure, camaraderie and excitement. And, sadly, some were joining to escape intolerable home situations. Many had a history of physical and sexual abuse, often by step-parents or ad hoc companions to their parents. A few applicants were in such distress that they were literally living on the street with no home at all.

What benefits accrue to these volunteers? First, the basics of life, food, clothing and shelter. Then medical and dental care — a first for many of these young people. Supervision, direction and discipline — something which many needed and had never experienced. Money in their pockets — important to anyone's self esteem. The Armed Forces provide a wide opportunity for continuing education, completion of high school, learning a trade, or generous help towards college as seen in this recent ad in a national magazine. Many youngsters who enlist at an early age anticipate retirement at 40 with a pension and the prospect of a civilian job.

Finally, this system takes a large number of youngsters who are at loose ends with NOWHERE TO GO. They are off the streets and have a purpose in life and a goal. Large numbers of idle, aimless persons in the community would be a danger that could seriously destabilize our social structure.

Ralph Fried, MD, is a retired pediatrician living in Cleveland, Ohio.

The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

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News Digest

Edited by Deborah Athy



Vanity, thy name is . . . man?

Recent statistics show that 5,440 of the facelifts done in 1984 were on men — a substantial increase which could be attributed, in part, to man's desire to appear youthful, says Melvin Dinner, MD, a plastic surgeon from Beachwood, Ohio. Dr. Dinner spoke at the 1985 Health Care Conference, sponsored by the Ohio Society of Certified Public Accountants in Columbus.

The peak ages of the patients seeking facelifts, wrinkle removal and eyelid lifts are from the late 40s to the early 50s. "That's when people are beginning to show their age," Dinner says in an article in the *Columbus Dispatch*.

But there is no denying the fact that a youth-oriented culture is pushing more and more men into trying facelifts, he adds.

"Whether they're in sales, or doctors, dentists, accountants or television personalities, men see themselves as more saleable from a youthful point of view."

Gentlemen, welcome to the club.

Smokers shouldn't hold breath waiting for safe cigarettes

Smokers waiting for a "safe" cigarette which will not cause further harm to their health shouldn't hold their breath, says James Chaplin, director of the U.S. Agriculture Department's Oxford (N.C.) Tobacco Research Lab.

For the last six years, the lab has focused on reducing tar in tobacco; but Chaplin says, "We're not that close. It's a slow process."

Two of the lab's 10 scientists have been working on breeding tobacco plants with a lower level of tar by crossing lines with low tar and less-than-desirable smoking qualities and the usual amount of tar.

Although some 550 samples were grown this year, the scientists can test only 300 samples a year, because they have to cure the tobacco, make it into cigarettes, and smoke them on smoking machines that analyze the tar and nicotine.

"We haven't come up with a real fast method of analyzing for tar," says Chaplin. "We can go much faster if we didn't have to go through that process."

Healthy eating on the job

Two non-profit nutrition organizations, the Society for Nutrition Education and the American Dietetic Association, have joined forces in a three-year project to improve "Nutrition at the Worksite."

The study, designed to enhance nutritional consciousness "on the job," will develop nutritional programs to be incorporated by employers. The organizations will work together to train nutritionists and health educators as worksite consultants, and will make resource materials available for use in the program.

The study is being funded by the Office of Disease Prevention and Health Promotion of the US Department of Health and Human Services.



a compilation of the latest developments, reports and products of interest to physicians.

Thermography may reveal neurological problems

The haziness that surrounds some neurological problems may be clarified by the use of thermography — a technique which involves photographing variations in the surface temperature of the body.

Victor Lerman, MD, of Montgomery, has devised a method based on the use of thermography to reveal hidden neurological abnormalities.

His approach involves immersion of the affected extremities in cold water, followed by a series of thermograms which document their rewarming process. The different colored patterns which appear in the thermograms may help physicians isolate the source and cause of nerve damage.

Lerman recently presented his technique, "Cold Test Serial Thermography," at the 13th World Congress of Neurology in Hamburg, Germany.

Aspirin bottles may carry warnings

By June 1 of this year, aspirin bottles may carry messages warning parents of children and teenagers about the possible link between aspirin and the deadly Reye's Syndrome.

Reversing its previous policy, the Food and Drug Administration is taking action to require warning labels on aspirin bottles, effective after May 30, 1986. The labeling would be mandated through regulation, not legislation.



A team of medical students from East Tennessee State University get ready to answer the next question posed in the "Caduceus Games," an unusual competition patterned after the old "College Bowl."

The correct answer is . . .

Medical school was never like this.

Two teams of medical students sit hunched on platforms behind buzzers, waiting for the next question.

"What is the etiological agent of Rocky Mountain spotted fever?"

Buzz-z-z.

"Rickettsia rickettsii."

"Right."

Of course, that's not *really* the way East Tennessee State University's Quillen Dishner School of Medicine conducts its classes. But, in the interest of injecting an element of fun into the school's typically arduous curriculum, Dean Herschel Douglas, MD, created the first annual "Caduceus Games" to provide the students with some "healthy competition in a medical event they can enjoy."

Patterned after the old General Electric "College Bowl," the games are meant to foster interaction among the four medical schools in the area. The winning school, the University of Southern Alabama, received $5,000 in scholarship awards; the runner-up, $2,500.

Faculty at the participating schools contributed to a pool of 2,000 questions, and ruled on partially correct answers.

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Ohio medi-scene

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New hope for heart attack victims to be tested in Columbus

Riverside Hospital will be one of only five hospitals nationwide to launch an experimental heart attack treatment program which will test a new anti-clotting drug in combination with balloon catherization, says Erie Chapman III, president of Riverside Hospital.

At a recent news conference at Riverside, doctors referred to the drug, tissue-type plasminogen activator, or TPA, as "revolutionary," saying it has the potential to "limit or stop heart attacks in 85% of all cardiac patients."

"Over the next several years, we like to think thousands of lives will be saved with the use of this drug," Chapman says.

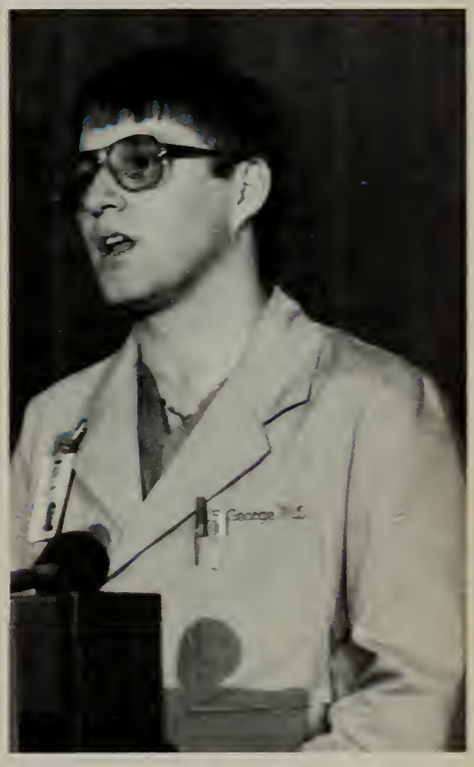
TPA "dissolves clots in the arteries of heart attack patients and restores blood flow," says Barry S. George, MD, associate director of cardiology, who will head the study. Genetic engineering has made it possible for TPA, which is a naturally occurring enzyme, to be synthesized by Genetech, a company in California.

In the past, other drugs, such as streptokinase, have been used in similar capacities as clot dissolvers, but have shown a tendency to cause bleeding complications. The distinguishing characteristic of TPA, according to George, is that it is "clot specific," and appears to dissolve only recently formed clots.

Although TPA appears to be effective in dissolving clots, fatty materials in the arteries may still be present after the drug is injected, George says. For this reason, balloon catherization will be performed to remove residual blockage and to improve blood flow. Without catherization, it is likely that clots would form again, George explains.

Because the program is still in its infancy, the timing of the catherization procedure remains "somewhat randomized," George says. "We don't know if it's best to use the balloon procedure at the time of injection or seven to 10 days later," he admits. This is one gray area George and others hope to clear up as the study progresses.

Even so, studies indicate that the combination of TPA and catherization is "an accurate and perhaps superior modality for treatment of heart attack patients," George points out.



Barry George, MD, explains how TPA works at a recent press conference.

At present, some 30 to 40% of heart attack patients never make it to the hospital because of overwhelming heart muscle damage. "Patients must be aware of the kind of symptoms they're having," in order to avoid extensive heart muscle damage, says Richard J. Candela, MD, director of Interventional Cardiology. "Speed is of the essence."

To be eligible for the treatment, patients must give their consent,

Ohio medi-scene ... continued

New hope ... *continued*

must be between the ages of 18 and 70, and must have had chest pains for less than four hours.

The study will include approximately 300 to 400 patients from all five participating hospitals, with about 75 to 100 of those coming from Riverside, George estimates. The other hospitals in the study include: Christian Hospital, Cincinnati; University of Michigan Hospital; Beaumont Hospital, Detroit; and Duke University Hospital in Durham, N.C.

The length of the study remains somewhat open-ended, George says, although he expects it to continue anywhere from six months to one year. — *Deborah Athy*

$1,000,000

More about mandated coverage

Editor's note: The following summary updates the article which ran in the January issue on the $1 million liability coverage now being required of physicians by some Ohio hospitals (see "The $1 Million Question," January, 1986). The summary has been distributed to OSMA's Council, and is printed here for your information.

A survey conducted by the AMA Hospital Medical Staff Section indicated that approximately 84% of responding registrants at the HMSS Annual Assembly last June said that their hospitals required physicians to have some level of coverage. The specific level ranged from $100,000 at four hospitals to $10,000,000 at one hospital. The most frequently stated mandate was $200,000 to $2,000,000.

Some hospitals have been accepting informal statements from physicians regarding the level of coverage carried by an individual physician. The St. Paul Insurance Company and the Ohio Hospital Insurance Company report that the preferred and strongly suggested method of providing proof of the existence of a stated level of coverage is for the physician to provide the hospital with a copy of the declaration page or certificate of insurance.

Here are various methods for dealing with the mandated $1,000,000 coverage which have been researched by the OSMA Staff.

1. It is possible that mandated coverage could be carried or paid for by an entity other than the physician. For example, a New York statute enacted in July, 1985, requires all of New York's 278 hospitals to provide coverage in excess of $1,000,000 for a physician with medical staff affiliation, if requested by the physician.

Ohio VA hospital looks at stress disorder

The Center for Stress Recovery, at the Veterans Administration Hospital in Brecksville, Ohio, is giving close attention to post traumatic stress disorder (PTSD) — still a controversial subject nationwide, since it is difficult to diagnose and cases of it have not been well documented.

Only 13 VA hospitals nationwide offer inpatient care for PTSD, and the Brecksville facility is the only one with a comprehensive, funded program for finding the best ways to deal with the disorder.

Symptoms, which often include nightmares and emotional numbing, are difficult to detect because they may be only intermittent, or they may be manageable and not interfere with the patient's life — "until the guy goes to a film on Vietnam or goes to the Vietnam War Veterans Memorial in Washington," after which he may experience the symptoms intensely, says Jack Smith, director of the Brecksville Center, in an article that ran in the *Columbus Dispatch*.

Smith says there are 10 inpatients and 30 outpatients, but no one has yet completed both phases of treatment, since treatment averages about a year. The program may release some patients this summer, however.

"Ultimately, we're looking at 60 beds inpatient capacity and over 1000 patients," Smith says.

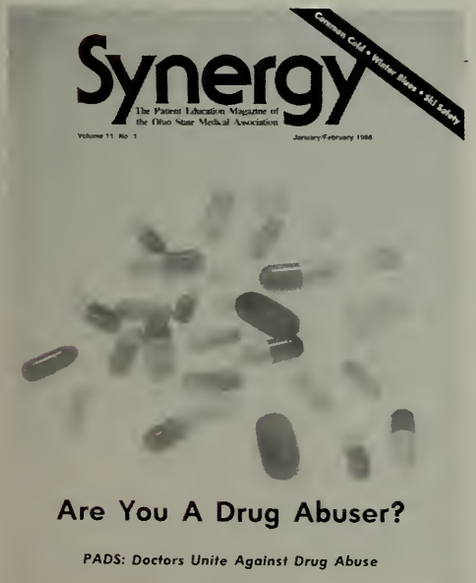
2. Hospitals could seek alternative methods of purchasing insurance. The hospital could create a self insurance mechanism to comply with the $1,000,000 mandate. However, this alternative is not recommended and is considered too risky. Hospitals could also seek coverage from a carrier that does not require the $1,000,000 coverage. Although investigation indicates that new or additional carriers that might choose to sell hospital professional liability would insist on the same coverage requirement.

3. Another option is to bring suit against the hospitals and insurers who require the excess coverage. This option has been found to be less than desirable since judicial opinion has supported the appropriateness of the mandated coverage in other jurisdictions. However, research shows that there is a new antitrust suit pending in federal court in Illinois, filed by physicians at the McDonough County District Hospital, Macomb, Illinois, charging restraint of trade by mandating the $1,000,000 coverage.

4. Different levels of mandated coverage based on geography/risk classification could be negotiated. OSMA research indicates that St. Paul and OHIC have both considered and rejected this alternative. Reasons given by these companies are: ease of administration and the base requirement would be $1,000,000 for all physicians and then would be increased from $1,000,000 rather than decreased.

5. There are several potential legislative reforms such as use of Joint Underwriting Association or Stabilization Reserve Fund monies to pay for the excess coverage; mandate insurance coverage, but at a lower level (e.g., $200,000), or on a risk classification basis; joint and several liability statutes so that hospitals would not be required to pay judgment against physicians, thus negating the rationale the hospitals have used for the $1,000,000 coverage.

Other options and activities will be investigated and additional information will be forthcoming as it is available. — *OSMA staff*



Synergy: More for your money and your reception area

Patients waiting in your reception area will find more to read in *Synergy* this year. The OSMA's patient education magazine has been expanded to 16 pages and will include a variety of articles on health and fitness, as well as information on the socio-economic side of medicine and health care.

This year's *Synergy* also features a higher quality of paper and two colors of ink for a more striking cover and more inviting interior graphics and design. To accommodate these changes and stay within the budget, however, *Synergy* will be published only 10 times a year, which will save the OSMA substantial printing and mailing costs.

Also new to *Synergy* is A. Robert Davies, MD, who is now serving as the magazine's consulting medical editor. In this capacity, Dr. Davies, a member of the OSMA Communications Committee, will review story ideas and completed articles for *Synergy,* in order to assure the most accurate and timely information possible.

Ohio medi-scene . . . continued

More for your money . . . *continued*

You will also notice that the articles in *Synergy* this year will be tied more closely to the feature stories appearing in the *Ohio State Medical Journal.* For example, both the January *Journal* and the January/February issue of *Synergy* feature cover stories on prescription drug abuse in Ohio and PADS, the OSMA's new program to crack down on those professionals facilitating drug abuse. Articles in the two publications are being coordinated to provide you and your patients a forum for talking over health and medical issues important to both of you.

Synergy, which began as *Your Doctor Reports* over ten years ago, has evolved over the past several months from a four-page health-oriented newspaper to a compact magazine format, making it easier to display in your waiting room and simpler to photocopy articles you feel would be of interest to your patients. Its subject matter has also been expanded to include a wide variety of topics — from HMOs and PPOs to the latest medical research in Ohio.

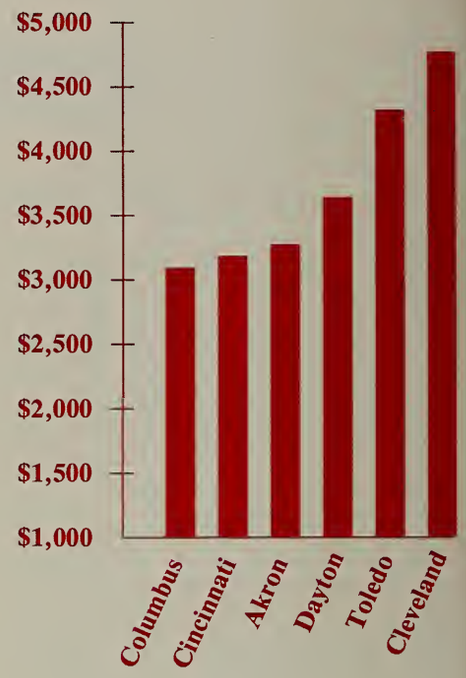
Your copy of *Synergy* is also being mailed directly to your office this year instead of your home, to facilitate its placement in your reception area. Remember, *Synergy* is designed to inform and educate *your patients,* and — as the name implies — to show your patients that you are working with them for the benefit of their health, safety and overall well-being.

Because *Synergy* is designed to be a waiting room publication for patients, it no longer will be mailed automatically each month to retired physicians and medical students. However, any retired or student member who would like to continue receiving it may write: Synergy, OSMA, 600 South High Street, Columbus, Ohio 43215.

In addition, physicians may still order extra copies of *Synergy* to distribute to their patients at the same low bulk rates. For example, 100 extra copies of each issue of *Synergy* can be purchased for as low as $240.00 per year. For a special order blank, you can write to the same address above.

Remember, both *Synergy* and the *Journal* are your publications, and — as such — we want to present your knowledge, insights and perspectives in the articles included in both. The January 8, 1986 issue of the OSMAgram included a questionnaire asking you to lend your expertise by serving as interview sources for these two publications. Those who have not yet filled out the blue questionnaire are encouraged to do so as soon as possible.

With society's increased emphasis on health and fitness — as well as the numerous changes taking place in the health care system today — it is crucial that patients have access to sound, reliable and expert information and advice. Through *Synergy,* the OSMA is working hard to facilitate this process — and to share medicine's point of view with the public. — *Susan Porter*



Ranking Ohio's hospital rates

Hospital stays are expensive no matter where you are, but according to a survey published by the American Hospital Association, Columbus has one of the lowest hospital rates in Ohio — and one of the lowest in the nation.

With an average cost of $3,387 per admission, Columbus ranked behind Cincinnati at $3,435; Akron at $3,492; Dayton at $3,785; Toledo at $4,200; and Cleveland at $4,696.

At the top of the nationwide survey was Boston, with an average admission cost of $6,013; followed by Detroit ($5,039) and Philadelphia ($4,820).

Madison, Wisconsin came in with the lowest average cost ($3,326), followed by Des Moines, Iowa ($3,384) and Columbus.



Medical research and studies in Ohio

• **Monoclonal antibodies fight cancer . . .** Research conducted by pediatrician Nai-Kong V. Cheung, MD, of Cleveland, has shown that a new series of monoclonal antibodies is successful in tracking down cancerous tumors and fighting them, one on one, without expending any of their cancer-fighting energy in healthy tissue. At this point, the treatment is being used to fight neuroblastoma, but the use of antibodies might be similarly used in the future to treat other cancers, including lung, breast, bone and skin cancer, says Dr. Cheung.

• **Teens and junk food . . .** Teenagers are notoriously bad eaters, but current lifestyles and peer pressure are rapidly turning today's adolescents into "junk food junkies," says Barbara Comer, MD, Columbus. Dr. Comer and nutrition researcher Virginia M. Vivian have completed a study of the diets and eating habits of 500 adolescents, aged 12 to 18 years, in which they found that food selections by this age group are made with little regard to proper nutrition. The researchers call for a thorough class in proper nutrition or behavior modification, as well as more parental guidance to help solve the problem.

• **Mammary artery proves best for bypass surgery . . .** A 10-year study, conducted by the Cleveland Clinic Foundation, has shown that coronary bypass patients live longer when the surgeon uses a mammary artery rather than a leg vein graft. The study found that those patients who had leg vein grafts had a 61 percent higher death risk and a 41 percent higher heart attack risk than the mammary artery patients. The vein-graft patients also had more hospitalizations and surgeries, and were more likely to develop blockages in the vein grafts than the mammary-artery recipients. According to Bruce Lytle, MD, one of the study's authors, the mammary artery was more efficient than a vein in keeping itself clean of deposits that could clog blood flow. "The bottom line is that they have a statistically better chance of survival," he says.

• **Immunobiology of cartilage . . .** Jerome H. Herman, MD, professor of medicine, Division of Immunology, has spent the last few years researching products which play an important role in the control of the catabolic and anabolic state of cartilage — important because the attack on cartilage in diseases like rheumatoid arthritis and osteo-arthritis requires control by therapy to prevent destruction and deformity. Some of these special materials include Catabolins, which are products of the immune cells, particularly from the interaction of monocytes and T-cells, and also the synovium itself. Another recently recognized material is Anabolin, which is a product of T-lymphocytes and pathologic synovium. A special culture technique for growing synovium and assaying these materials has been established, and the effect of many of the drugs used in the treatment of rheumatic diseases have been studied for their role in either turning on or turning off these materials.

• **Studies on drug-related lupus models . . .** Evelyn Hess, MD, professor of medicine and director of the Division of Immunology, has a continuing program to study the mechanism and role of drugs which cause a lupus-like syndrome in patients. Recent work has highlighted procainamide, commonly used in the control of cardiac arrhythmias and often associated with a slow acetylator phenotype. Tests with laboratory animals were studied to detect genetic differences. The data suggest there may be a significant variability with respect to the extent of apparent non-acetylation metabolism which may contribute to susceptibility to procainamide-related autoimmune disease. The investigators have also developed new analytical techniques to detect the metabolites of procainamide and other drugs.

• **Brain resuscitation clinical trial II study . . .** Akron General

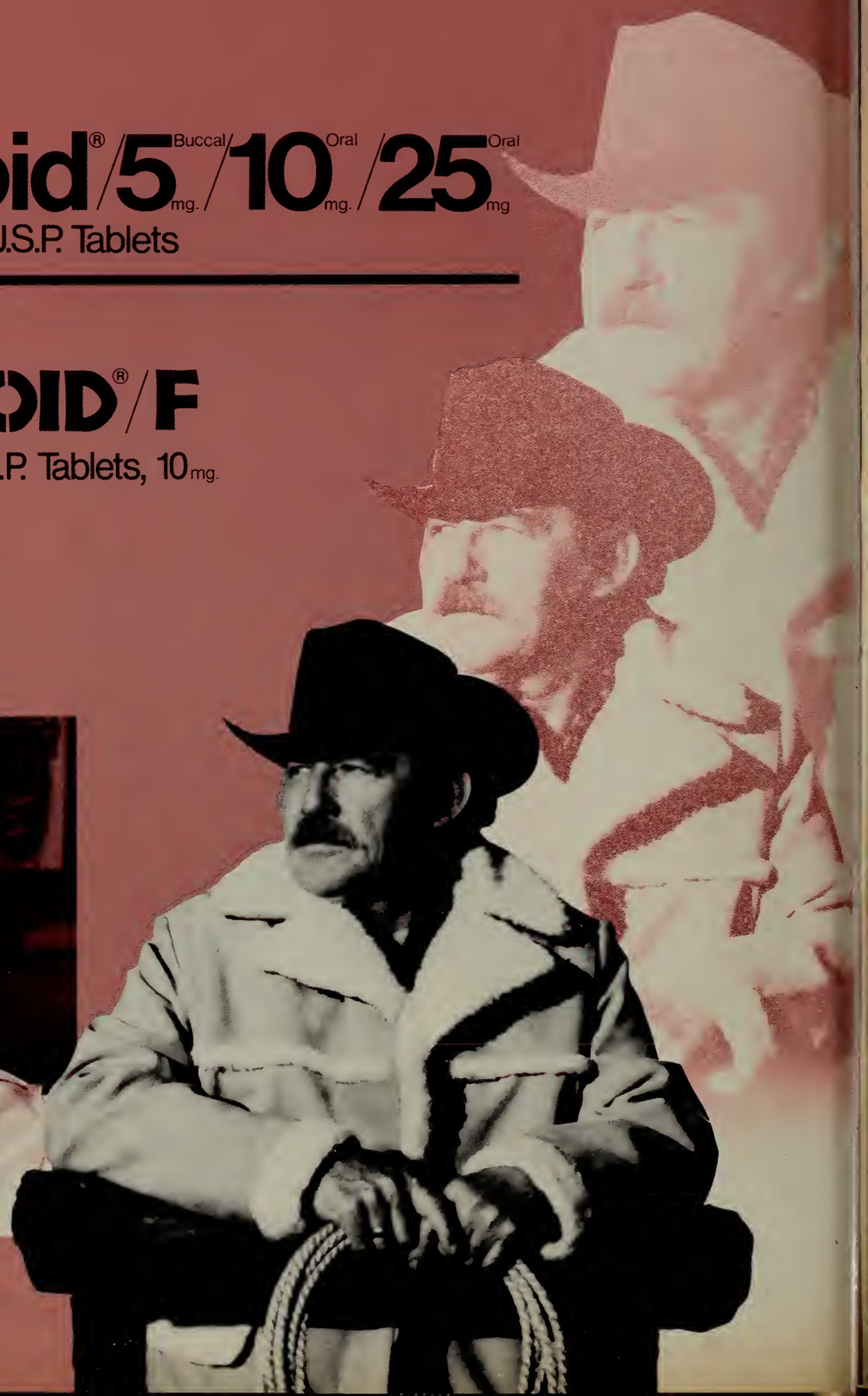
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Ohio medi-scene ... continued

Medical Center, under the direction of Darell Heiselman, DO, is participating in a double-blind, placebo-controlled study which is evaluating the effects of Lidoflazine, a calcium channel blocker, when given to persons who have suffered a cardiac arrest. It is anticipated that the drug will prevent or decrease the amount of brain damage they will suffer. The research is directed by the University of Pittsburg, and involves 20 hospitals in seven different countries.

• **Effect of cimetidine and chloramphenicol . . .** Dr. Darell Heiselman and Dr. Lou Cannon, at Akron General Medical Center, are currently studying the possibility of bone marrow suppression when cimetidine and chloramphenicol are given together. Patients between the ages of 18 and 80, who meet the criteria for entering the study, will be placed at random on chloramphenicol or cimetidine and chloramphenicol. The purpose of the study is to compare the safety and efficacy of chloramphenicol alone and/or in combination with cimetidine in the treatment of serious infection and to determine if cimetidine affects the blood levels or incidence of side effects of chloramphenicol.

• **Multiple physician and the patient . . .** Arnold Allen, MD, professor of Psychiatry at Wright State University School of Medicine, is exploring the effect on patients of the growth of group practices, and the demand by these groups that the patient interact with multiple physicians.

• **Topical anesthetics in wound care . . .** Mark Eilers, MD, assistant professor of Emergency Medicine at Wright State University School of Medicine, is developing a research model to test the effectiveness of a topical anesthetic in wound care management. Currently, infiltrative anesthetics used in wound care management are applied by injection — causing local tissue injury, pain, patient discomfort and potential introducing of infection material. Dr. Eilers will investigate the possibilities of an effective and safe route of topical anesthetic application for potential investigating in human subjects. — *Compiled by Karen S. Edwards; Darell Heiselman, DO; and Evelyn V. Hess, MD*

If you are presently conducting research and would like your work to be featured in a future article, please send a one or two paragraph summary of your study to: Executive Editor, The Ohio State Medical Journal, 600 S. High St., Columbus, Ohio 43215.

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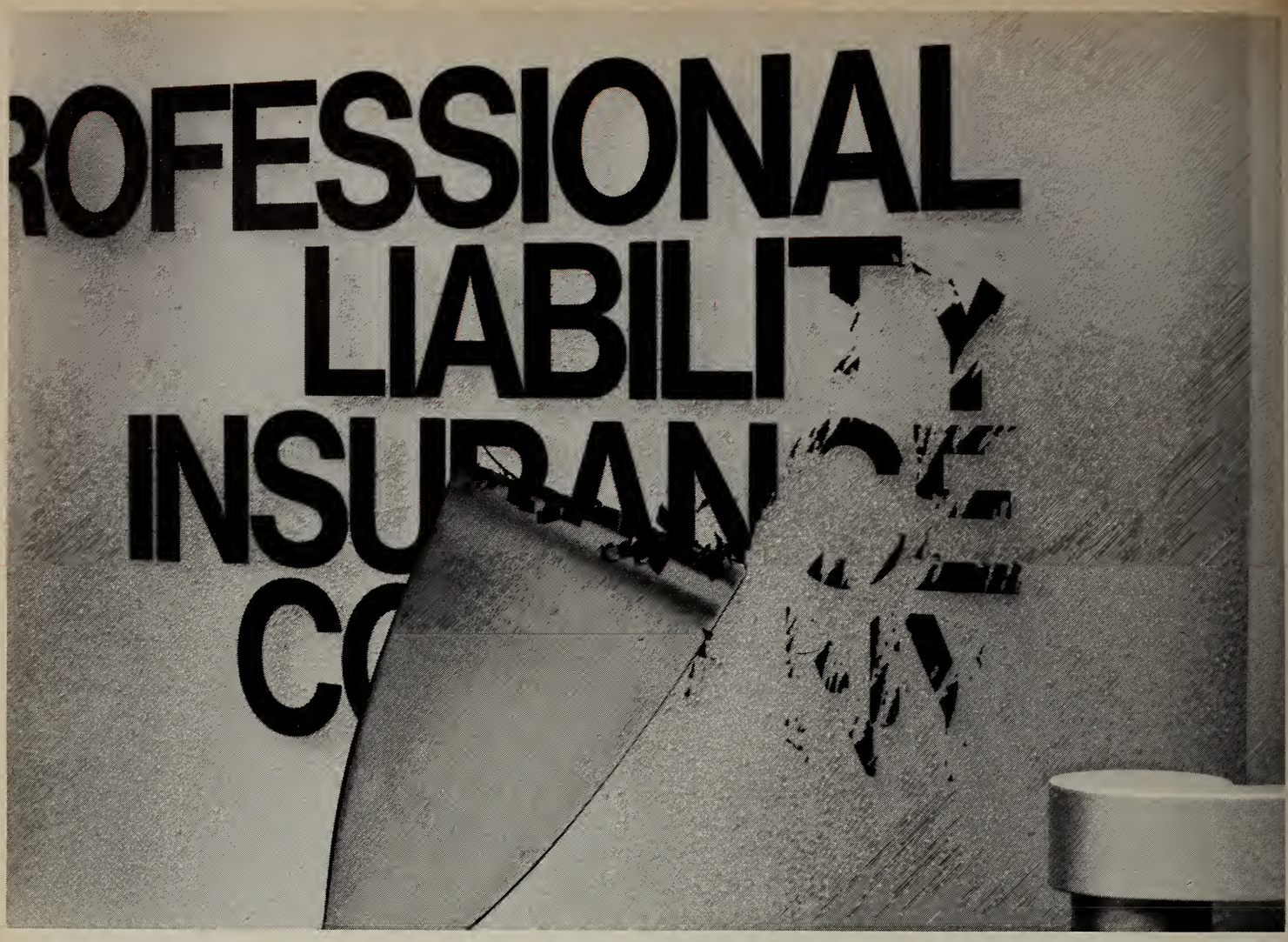
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The AMA Interim Report

By Oscar Clarke, MD, and Herman I. Abromowitz, MD

How Ohio voted . . .



This report covers some of the important issues voted on by the Ohio Delegation at the 1985 Interim Business Meeting of the American Medical Association in Washington, D.C., December 8-11, 1985.

There were 67 reports and 122 resolutions considered by the House of Delegates.

Self-Governance of the Medical Staff

The American Medical Association House of Delegates adopted the following substitute resolution submitted by the Ohio Delegation in lieu of a resolution submitted by the Hospital Medical Staff Section:

"**RESOLVED,** That the JCAH Commissioners of the AMA work to revise JCAH standards on medical staff by removal of those provisions which permit unilateral amendment of medical staff bylaws by the Board of Trustees (paragraph 10.2.8)."

The Ohio Delegation unanimously supported adoption.

Physician Conflict of Interest

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association House of Delegates request the Council on Ethical and Judicial Affairs to continue to review its 1984 Conflict of Interest Guidelines, and to amplify them as needed to address current and emerging situations relating to financial interests of physicians in organizations involved in the provision of medical services."

The Ohio Delegation unanimously supported adoption.

Joint Ventures, Ethical Obligations

The AMA House of Delegates adopted a substitute resolution that asks the AMA to redistribute Opinion 4.04 of the Current Opinions of the Council on Ethical and Judicial Affairs. That opinion requires the physician to disclose his ownership of a health facility to his patient prior to admission or utilization of the facility.

The Ohio Delegation unanimously supported adoption.

Preadmission Certification

The AMA House of Delegates referred the following resolution to the Board of Trustees for a report back to the House of Delegates at the 1986 Annual Meeting:

"**RESOLVED,** That the American Medical Association develop appropriate preadmission certification standards; and be it further

RESOLVED, That the AMA seek to have these standards apply to all preadmission review conducted in the United States."

The Ohio Delegation supported referral.

Value of a "Gatekeeper"

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association undertake a study of the "gatekeeper" system, its advantages and disadvantages, and report back to the House of Delegates by the 1986 Annual Meeting."

There are a number of complex issues involved in the issue of so-called "gatekeepers," including the appropriateness of such an

addition of the health care system, the accuracy of the term "gatekeeper," and the best approach to establishing the value of such services when provided by physicians.

The Ohio Delegation supported adoption.

Protection of Peer Review Records in Litigation

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the AMA believes it vital that for peer review to be effective, peer review data must be kept confidential, and that the Association take whatever steps are necessary to implement this policy."

The Ohio Delegation supported adoption.

Value of a "Case Manager"

The AMA House of Delegates adopted the following resolution regarding the increased demands being made upon physicians for the management of the care received by their patients in a variety of settings, including both acute hospital and home care, without appropriate payment being made for such "case management" services, which are often quite time-consuming and complex:

"**RESOLVED,** That the American Medical Association undertake a study of professional fees for physicians who function as "case manager."

The Ohio Delegation supported adoption.

Medicare Fee Freeze

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association continue an aggressive activity, both legislative and judicial as appropriate, to eliminate the discriminatory action of Congress in imposing an unfair control of charges and reimbursement for physician services under Medicare; and be it further

RESOLVED, That the American Medical Association in pursuing this goal continue to strengthen and intensify its mechanisms for encouraging participation by state, local and specialty societies and all physicians in voicing the strongest opposition to this freeze to their members of Congress; and be it further

RESOLVED, That the AMA intensify efforts to increase public awareness of the deleterious effects of the Medicare fee freeze and other Medicare benefit curtailments, on the continued accessibility for Medicare-eligible citizens to the physicians of their choice." The Ohio Delegation unanimously supported adoption.

Massachusetts Legislative Action

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association maintain its vigorous opposition to the Massachusetts legislation which mandates that, as a condition of licensure, physicians who treat Medicare beneficiaries agree to charge or collect from Medicare beneficiaries no more than the Medicare allowed amount, and that the Board of Trustees be commended for its timely response in challenging the validity of the Massachusetts law; and be it further

RESOLVED, That the American Medical Association strongly affirm the policy that medical licensure should be determined by education qualifications, professional competence, ethics and other appropriate factors necessary to assure professional character and fitness to practice; and be it further

RESOLVED, That the American Medical Association oppose any law that compels either acceptance of Medicare assignment or acceptance of the Medicare allowed amount as payment in full as a condition of state licensure."

The Ohio Delegation unanimously supported adoption.

Committee on Professional Liability

The AMA House of Delegates adopted a Board of Trustees report which recommends that the Committee on Professional Liability be reconstituted as an Advisory Panel to the Special Task Force on Professional Liability and Insurance with the following characteristics:

1. That it be made up of eight physicians, reflecting different areas of medical practice and different areas of the country, appointed by the Board and the Speaker of the House.
2. That its function be to advise the Special Task Force and to work with the Special Task Force on any activities within the scope of the problem of professional liability.
3. That the Panel meet with the

Special Task Force at least three times a year and that its members be available for consultation on an individual basis at any time to the Special Task Force.

4. That its members be available to represent the AMA and the Special Task Force to governments, the media, to Reference Committees and other organizations that are, or should be, concerned about professional liability.
5. That its members play a special role in coordinating the activities of the Special Task Force with the Councils of the Association, and with state and specialty societies.
6. That the Advisory Panel report jointly with the Special Task Force to the Board and the House of Delegates.

The Ohio Delegation unanimously supported adoption.

AMA Coalition for Tort Reform

The AMA House of Delegates referred the following resolution to the Board of Trustees:

"RESOLVED, That the American Medical Association actively work to establish a coalition for tort reform to be comprised of representatives of the AMA, other affected professions, business and industry, and concerned individuals for the purpose of working together in a unified effort to formulate initiatives for effective and equitable reforms to the tort system or for the consideration of proposals for alternative mechanisms to the current tort reform system for settling medical malpractice and other liability disputes."

The Ohio Delegation unanimously supported referral.

Report of the Ad Hoc Panel on the Funding of Graduate Medical Education

The AMA House of Delegates amended and adopted the report from the Board of Trustees Ad Hoc Panel on the Funding of Graduate Medical Education which reviews recent actions of the Department of Health and Human Services and proposed federal legislation which affect Medicare funding of graduate medical education, and presents a series of principles to guide the AMA in responding to legislative proposals and to the challenges to the graduate medical education system.

In addition, the AMA House of Delegates referred the following resolution on the same subject:

"RESOLVED, That the American Medical Association develop policy relating to and encourage federal and non-federal funding sources for graduate medical education to supplement current programs."

The Ohio Delegation unanimously supported these actions.

Physicians Supply — Progress Report

The AMA House of Delegates filed a Board of Trustees report regarding physician supply and distribution in the U.S. The report, which is a preliminary report of the AMA Task Force on Physician Manpower, describes information that has been collected, identifies some determinants of the need for physician manpower, and contrasts opinions of the profession and the public on the subject. The Board of Trustees will consider having the Task Force conduct an attitudinal survey of the membership, develop a system that will allow for trend analyses, obtain input from other organizations, and develop a strategy for changing the public's possible misconceptions about manpower issues.

The Ohio Delegation supported this action.

Regulation of Clinical Education Provided in U.S. Hospitals for Students in Non-LCME Accredited Schools

The AMA House of Delegates adopted an amended report of the Council on Medical Education recommending:

1. That the House of Delegates reaffirm its objection to the substitution of core clinical clerkships in U.S. institutions for the core clinical curriculum of a foreign medical school;
2. That the American Medical Association urge the state licensing boards, or other appropriate state agencies, to develop regulations directed toward protecting patients and assuring the quality of core clinical clerkships, for students that are not enrolled in a medical school accredited by the Liaison Committee on Medical Education (LCME), to be provided only in hospitals with experience in undergraduate medical education and with accredited residency training in the field of clerkship.

The Ohio Delegation supported adoption.

Credentialing Procedure

The AMA House of Delegates adopted a Board of Trustees report recommending the adoption of a substitute resolution as follows:

"**RESOLVED,** That the AMA ask the JCAH to continue to monitor medical staff credentialing procedures, to include clearly delineated authority to an elected physician of the medical staff for access, review, and judgment over contents, to ensure that the individual medical staff member's credentials file contains only well documented and appropriate data and does not include information that is immaterial, misleading, or of questionable value."

The Ohio Delegation supported adoption.

Quality of Medical Care Monitoring

The AMA House of Delegates adopted the following two resolutions:

Quality Medical Care Monitoring: Not to be a Permanent Part of the Hospital Medical Record

"**RESOLVED,** That the American Medical Association urge hospitals to establish a policy that all medical quality care survey information be protected as privileged, and not become a part of the permanent medical record."

Reporting of Incidents

"**RESOLVED,** That the American Medical Association adopt as policy that:

1. All hospital reports mandated by state agencies or outside authorities involving individual physician care of patients should be reviewed by an appropriate medical staff committee prior to reporting;
2. Hospital medical staffs be given a reasonable period of time to evaluate any reports pertaining to a physician's care of patients;
3. The organized medical staff should seek the assurance of the state agency or outside authority that the report will remain strictly confidential.

The Ohio Delegation supported adoption.

Hospital Decisions to Grant Exclusive Contracts

The AMA House of Delegates adopted the following amended resolution:

"**RESOLVED,** That the American Medical Association support the concept that individual medical staff members who have been granted clinical privileges are entitled to full due process in any attempt to abridge those privileges by granting of exclusive contracts by the hospital governing body; and be it further

RESOLVED, That the AMA study and report all appropriate methods which assure that those rights are guaranteed and initiate whatever action is appropriate."

The Ohio Delegation supported adoption.

Media Advertising for Tobacco Products

The AMA House of Delegates adopted a Board of Trustees report describing AMA activities in opposition to advertising of tobacco products such as: Sponsorship of sporting events or cultural programs; marketing and advertising of clothes or other products bearing the name and logo of cigarette brands; arrangements with film productions to display prominently tobacco products or to depict smoking in motion pictures; publicity events such as sky writing or giant inflatable product displays; discount coupons and free samples; scholarships or public works donations; and point of purchase displays.

The House of Delegates also adopted the following amended resolution:

"**RESOLVED,** That the American Medical Association oppose any form of media advertising of tobacco products by initiating and supporting legislation prohibiting such advertising."

The Ohio Delegation unanimously supported adoption.

AIDS and School Children

The AMA House of Delegates referred a resolution to the Board of Trustees that asks the AMA to study the public health consequences of allowing children with AIDS and AIDS Related Complex to attend school, and to report back at the 1986 Annual Meeting.

The Ohio Delegation unanimously supported referral.

AMA Action Plan for AIDS and Related Conditions

The AMA House of Delegates adopted a Board of Trustees report describing the AMA Action Plan for AIDS that is focused primarily through physicians serving as resources for education and guidance in their communities.

The AMA Action Plan for AIDS will provide physicians with current information about AIDS

through various mechanisms including written and electronic media, conferences, liaison with other organizations, and interfaces with all sources of accessible information. Education of the public will occur principally through identification of physicians, medical societies and the Auxiliary as educational and informational resources within the community. In addition, the AMA will interface with various governmental agencies to facilitate adequate allocation of funding resources to AIDS research.

The Ohio Delegation unanimously supported adoption.

Therapeutic Substitution of Drugs

The AMA House of Delegates adopted a Board of Trustees report that describes AMA activities in monitoring state legislation that would authorize pharmaceutical or therapeutic substitution of a physician's prescription and provides additional examples of therapeutic substitution that may result in harm to patients. The AMA, through its Department of State Legislation, will continue to oppose state legislation authorizing pharmaceutical or therapeutic substitutes to a physician's prescription.

The Ohio Delegation unanimously supported adoption.

Public Awareness Program

The AMA House of Delegates filed one Board of Trustees report and adopted another report on the development results, evaluation, and future plans for an AMA public awareness program. The House of Delegates also adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association develop a national strategy for the implementation of the AMA Public Awareness Program that will coordinate local efforts to utilize the information and materials in the most effective manner to meet unique local needs and opportunities; and be it further

RESOLVED, That additional materials developed for the Public Awareness Program be directed at the continuing education of the public regarding the impact of changes in the health care system on quality and access to care; and be it further

RESOLVED, That an advisory committee to the AMA Public Awareness Program, consisting of five practicing physicians with some experience or exposure in public education/awareness programs, be appointed by the Speaker of the House of Delegates."

The Ohio Delegation unanimously supported these actions.

A National Study of Resource-Based Relative Value Scales for Physicians' Services

The AMA House of Delegates adopted a Board of Trustees report describing the Association's role in efforts to develop, in conjunction with researchers at Harvard University, a new relative value scale for physicians' services. The ultimate goals of the project are an across-specialty RVS, based on the resource costs of providing physicians' services (time, complexity, overhead, costs of specialty training), and a process to update the RVS. The study will have two major stages:

1. **Technical:** During this first stage, data will be collected on the various components of the resource costs associated with a subset of high-frequency/high-cost services. Physicians will play a central role in the estimation of such factors as the time and complexity associated with various services. A sample of 2,000 physicians will be surveyed by telephone to obtain information on the time involved and complexity of selected high-cost/high-volume services. A number of Technical Consultant Groups, composed of physicians selected from medical and surgical specialties, will advise the investigators on the survey and other data collection efforts, and will review all results. In addition, actual charge data will be collected and analyzed as well. The charge data will aid in the extension of the initial resource-based RVS to all physician services. The final product will be a resource-based RVS.
2. **Consensus Panel:** The consensus panel will consist of approximately 25 members. Half will be physicians, representing national medical organizations and drawn from a variety of practice settings. The other half of the panel will be drawn from third-party payors, leaders of business and labor, and health care-related professions. This panel will evaluate the methodology and RVS from the first stage, and will also consider broader issues of developing and using a relative value scale for physician reimbursement.

The AMA's role will involve, among other things:

— James S. Todd, M.D., AMA Senior Deputy Executive Vice President, will serve as a member of the small Advisory Committee to this project, advising on the overall objectives, direction, and methods to be used in the research;

— AMA will designate a senior research investigator to take part in the planning and design of the study and to provide consultation and liaison throughout the course of the study;

— AMA will assume the primary role in recruiting physicians — through the specialty societies — to be involved in this study; and

— AMA will provide analysis and tabulations of physicians' practice costs, including professional liability insurance.

The Ohio Delegation supported adoption.

Payment for Physician Services Under Medicare

The AMA House of Delegates adopted the following amended resolution:

"**RESOLVED,** That the American Medical Association support the position that payment for physician services under the Medicare program should include an indemnity system based on a defined schedule of allowances that would (1) be based on a realistic resource cost relative value scale, such as that being developed by Harvard University in cooperation with the AMA; (2) allow appropriate regional differences in allowances to reflect differences in the costs of practice; and (3) would indemnify patients for covered services, maintaining the rights of physicians and patients to enter into individual contracts wherein physicians establish their own fees and agree or not agree to accept amounts identified by the schedule of allowances as payment in full."

The Ohio Delegation supported adoption.

Motorcycle Safety

The AMA House of Delegates filed a Board of Trustees report which responds to an earlier resolution which asks the AMA to encourage legislation requiring motorcycle manufacturers to emphasize the dangers involved in the operation of these vehicles. This report summarizes the data obtained from a review of biomedical literature on motorcycle safety. It concludes that motorcycle safety is a significant public health issue. A final report, with recommendations, will be submitted at the 1986 Annual Meeting.

The Ohio Delegation unanimously supported this action.

Health Fairs

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association urge that emphasis of the health fair concept be primarily educational and informative; and be it further

RESOLVED, That the sponsors of health fairs and similar single purpose screening programs be encouraged to emphasize the importance of the establishment of a personal doctor-patient relationship."

The Ohio Delegation unanimously supported adoption.

Boxing and the U.S. Olympic Committee

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association reaffirm existing policy established by Substitute Resolution 26 at the 1984 Interim Meeting which states:

1. Encourage the elimination of both amateur and professional boxing, a sport in which the primary objective is to inflict injury;
2. Communicate its opposition to boxing to appropriate regulating bodies;
3. Assist state medical societies to work with their state legislatures to enact laws to eliminate boxing in their jurisdictions; and
4. Educate the American public, especially children and young adults, about the dangerous effects of boxing on the health of participants."

The Ohio Delegation supported adoption.

There are many excellent reports presented to the House of Delegates at each meeting covering a wide range of subjects that are of interest to physicians. These reports, prepared by the AMA Board of Trustees, councils, committees and staff, contain a wealth of information.

A listing, by title, of some of the reports follow. If you would like a copy of these reports, please contact the OSMA office.

1. Public Awareness Program
2. Direct Provider Payment for All Medicare Medical Services
3. Joint Venture with United States Pharmacopeial

Convention
4. Physicians' Relationships with Health Facilities
5. Hospital-Medical Staff Joint Ventures: An Update
6. AMA's DRG Monitoring Project and the Prospective Pricing System
7. Alcohol-Related Injuries Requiring Medical Care
8. Child Sexual Abuse
9. DRGs for Federal Health Programs
10. A National Study of Resource-Based Relative Value Scales for Physicians' Services
11. Renal Dialysis Services
12. Acute Arthritis Rehabilitation Guidelines
13. Effects of Pesticide Exposure
14. Health Effects of Smokeless Tobacco
15. Report of Panel on Lasers in Medicine and Surgery
16. Drugs and Athletes

Oscar W. Clarke, MD, Gallipolis, is Chairman of the Ohio Delegation to the AMA; Herman I. Abromowitz, MD, Dayton, is Co-Chairman of Ohio Delegation to the AMA and President of the OSMA.

Marketing tips

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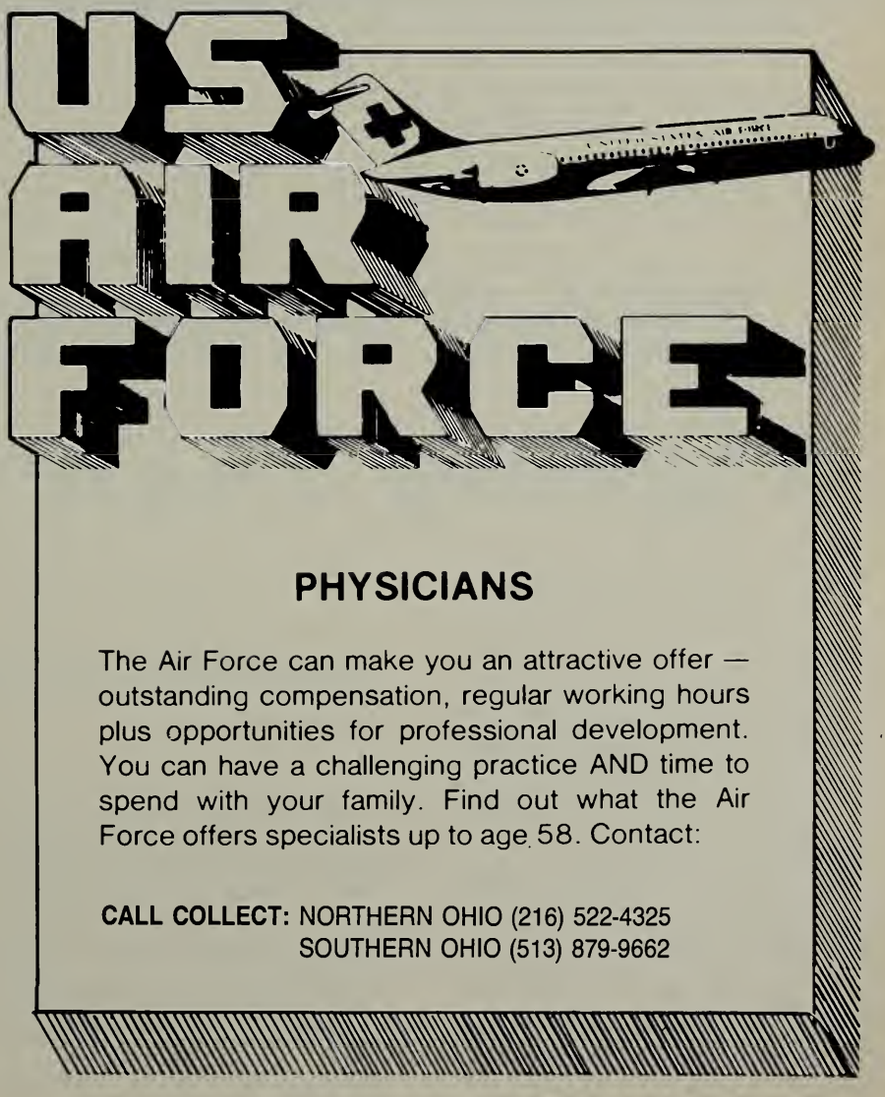
If your practice is open Monday through Friday, that computes to about 15 scheduling hours — making it more convenient for your working patients to schedule appointments and not cutting into your free time. — *Deborah Athy*

Please send me the following AMA report(s) listed in the Summary of Actions Report of the 1985 AMA Interim Meeting:
Report Number(s)_____

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Allied Professionals: Flexing Their Muscles

By Susan Porter

In 1960, Melodie Morgan, an exceptionally bright student and an early high school graduate, entered nursing school at the age of 17. But it wasn't until her last year of nursing education that she discovered what she really wanted to do with her life. "I was introduced to psychiatry," she recalls, "and it was love at first sight."

Her original plan was to seek advanced training and become a psychiatric nurse. "But nursing was just beginning to undergo its own personal revolution," she says. As a graduate of a three-year diploma nursing school, she knew her chances of being accepted into an advanced nursing program without first obtaining a baccalaureate degree were slim. And since four-year university programs would not recognize her three years of training, "I realized that in order to become a psychiatric nurse, I would have to start all over again," she says.

So following a complete re-evaluation of her career options and goals — along with some long and careful soul searching — Morgan decided to go to medical school instead. "I realized that I wanted to be independent — to

"Everyone wants to don a white coat. The action is as much symbolic as it is real."

have my own practice," she explains. "And I wanted to be financially self-sustaining. Professionally, I felt that the only way I could reach my own personal best was to go to medical school and become a physician.

Today, Melodie Morgan-Minott, who has a private practice in psychiatry in the Akron area, is one of only a handful of individuals in Ohio to make the transition from RN to MD. But she is not the only health care professional who, over the past two decades, was discontented with the limitations set by her original career choice.

In fact, if recent and current bills before the Ohio Legislature are any indication, it appears that nurses — along with the majority of other non-physician groups in health care: chiropractors, podiatrists, optometrists, psychologists and pharmacists, as well as physician assistants, physical therapists, respiratory therapists, dieticians, radiation technologists, social workers, emergency medical technicians and a host of others — are dissatisfied with at least some of the restrictions set by their present line of work. As a result, there appears to be a massive revolution underway which seeks to expand the scopes of practices of many of these groups and to grant them additional status, independence and opportunity in the health care marketplace.

"Everyone wants to don a white coat," says Bhagwan Satiani, MD, in an article called "The White Coat Syndrome," which appeared in the March 1983 *Bulletin* of the Academy of Medicine of Columbus and Franklin County. "The action is as much symbolic as it is real. As knowledge in the allied medical field exceeds the capacity of an individual physician to retain such diverse information, a horde of people are stepping in to fill the gap left by the physician."

One of the strongest and most comprehensive efforts by a group to gain more practicing privileges and responsibilities is represented by Substitute House Bill 315 — the Nurse Practice Act — which is now before the Ohio Legislature. This act would not only give nurses the right to "diagnose" patients' conditions and prescribe drugs for them, but would also allow certain "advanced practitioners of nursing" to establish independent practices for the purposes of providing entry-level care for patients. The bill, promoted by nurse educators, would expand the authority of the nursing board and remove current language in state statutes which restricts a nurse from practicing medicine. The nurses feel this move would upgrade the image of their profession and stimulate the dropping enrollment of nurses in BSN and MSN degree programs.

The bill — if passed in its present fourth-draft form — would clearly overthrow the traditional physician/nurse relationship, not only by allowing nurses to set up independent practices in direct competition with physicians, but also removing the supervisory power of the physician over nurse. Terms like "collaboration" and "collaborative practice" would be used to define the working relationship between doctors and nurses.

The 17 nursing groups promoting this bill are not the only allied professionals in recent months to bring a plea for more independence, power and privileges before state law makers. One bill currently pending, HB 494, could force physician-owned Independent Practice Associations (IPAs) to contract with chiropractors, podiatrists, optometrists, psychologists and dentists. Another piece of legislation would allow chiropractors to use hospital outpatient diagnostic facilities, while still another would grant hospital staff privileges to psychologists. In addition, dieticians, radiation technicians, and respiratory therapists currently have measures before the Legislature seeking state licensure and the right to establish independent boards to oversee their activities.

Among the many other groups to seek legislative change in recent years are physician assistants, who have asked to be registered independently of physicians so they can work directly for hospitals and HMOs, and optometrists, who want to diagnose and treat ocular diseases. Pharmacists also have periodically attempted to expand their professional activities, asking for the right to interpret and evaluate prescriptions, participate in drug selection, review drug utilization, and advise consumers on the therapeutic values, contents and hazards of drugs. And both social workers and counselors have sought and gained state licensure.

All of these varying requests have forced physicians, along with other health care workers, to continually re-examine and redefine their own professional goals, standards and activities, as well as to re-evaluate the relationships they have with each of the other groups. And, occasionally, public hearings before state bodies and officials have led to open confrontation between physician and allied practitioner, placing some strains on the day-to-day relationships doctors have with their nurses, medical technicians and other assistants.

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"The development of an allied group often starts with the identification of and creation of a teaching scheme — and is followed by use of people in that scheme."

"The traditional liaison of physician and nurse has, in recent years, come into jeopardy," says Claire V. Wolfe, MD, chairman of the OSMA's Nurse Liaison Committee. "Nurses might say this is because of the reluctance of physicians to adapt to changing times and practice patterns — the changing role of nurses in a rapidly changing environment. Physicians might say this is because of the aggressiveness of better educated nurses who really want to practice medicine without going to medical school. The issue is: Who determines the practice and scope of medicine? Who determines the practice and scope of nursing? Who determines when one intrudes on the other? Such questions form part of the current controversy between our two professions, a controversy that has unfortunately gone public over certain provisions of H.B. 315."

The reasons for this move — not only by the nurses, but by the numerous other allied groups seeking to expand their scopes of practice — are many, and to a large degree parallel the same issues that have resulted in the recent upheaval of the health care system itself. Paramount among the issues is the question of the cost of delivery of care. With the current pressure by business, government and other third-party payors to keep health care costs down, using lesser-trained and presumably lesser-paid individuals to accomplish the work of physicians is an inviting concept to many.

"There is a prevailing attitude that hospitals are high cost centers and that physicians are somehow at the center of these high costs," says Robert E. Schulz, MD, a long-time member of the OSMA's Committee on State Legislation. "Therefore, many providers believe that the paramedical groups can provide care more cheaply — and save a certain number of budget dollars," he says.

But not everyone agrees that the use of allied professionals will reduce health care costs. "It may be cheaper initially," says Dr. Schulz. "But once the cost of overhead and staffing is built into the infrastructure — it isn't going to be any cheaper for them to provide the care than it is for a physician." Some even contend that increasing the number of individuals allowed to provide care actually will make health care costs rise. "I don't believe for a minute this will result in a reduction of costs," says Richard D. Ruppert, MD, another member of the state legislation committee, president of the Medical College of Ohio, and a former vice chancellor for health affairs of the Ohio Board of Regents. "The cost of health care equals the cost per unit times the number of units," he explains. "So when you add more units to the system, the cost will go up," as each group tries to get its share of the market.

An even stronger contention is that if lesser-trained individuals are allowed to provide entry-level care, appropriate care may be delayed and, subsequently, cost the patient more, both in time and money. And a misdiagnosis could lead to critical delays in the delivery of the appropriate care and may even aggravate the situation.

"I have seen two cases recently where patients experienced shoulder pain caused by a tumor in the lung," says John Burkhart, MD, a past member of the state's Physical Therapy Board and current member of the OSMA Committee on State Legislation. "Let's say those patients had gone to a physical therapist first. A physical therapist could not have diagnosed a tumor. Instead, the shoulder pain might have been treated with heat — and if deep heat had been used, this might have spread the tumor and speeded up its growth."

Another issue related to cost is that of reimbursement and the move by allied practitioners to qualify for and seek direct payment for their services, without physician intervention.

Catherine Costello, JD, legal counsel for the Ohio State Medical Association and the former director of state legislation, agrees, stating, "Independent practice is a key factor. Economics motivates the allied practitioner, just as economics has brought about many of the changes in health care today."

Direct reimbursement, she adds, would allow allied practitioners to go into practice by themselves, advertise independently and develop their own patient bases. And even those who do not want complete economic independence from physicians are still trying to assure themselves some portion of the health care dollar, she adds, and are continually seeking ways to expand their services in the marketplace.

Thus, competition is still another contributing factor. "We are getting into a very competitive atmosphere," says Oscar Clarke, MD, past president of the Ohio State Medical Board and chairman of the OSMA delegation to the American Medical Association. "Where there is competition, you are bound to get differing points of view."

Still, it is important to remember, says Dr. Clarke, that much of the current problem with competition rose out of a critical shortage of physicians in this country in the past — and the physician's desire to have specially trained individuals to assist with

continued on page 176



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"Where all of these allied groups fall way short is in the area of diagnosis."

daily and routine care. "There was — and still is — a real need for the allied medical professions," he comments. "Let's face it. We couldn't practice without them. And while the need may not be as great as it was twenty years ago or after World War II, when you plant a garden, it's going to grow."

The rise of the health care allied practitioner also parallels, to a large degree, the development of highly sophisticated medical technology and the trend towards specialization. "There has been an explosion of knowledge in recent years," Dr. Schulz points out. "So it is difficult for the individual physician to maintain the degree of specific knowledge in any given area that someone who specializes in that area may be able to maintain."

With the need for medical assistance and the increase in high technology and specialization has come the development of educational programs designed to train individuals to perform these tasks.

"The development of an allied group often starts with the identification of and creation of a teaching scheme — and then is followed by the use of people in that scheme," says Ray Bumgarner, executive director of the Ohio State Medical Board, who has witnessed the emergence of a number of these groups.

Bumgarner explains that once these individuals are trained and at work, there is generally a move of some sort of registration — generally by a voluntary body — in order to make sure that only qualified individuals are employed in that line of work. "Then, as the occupation becomes more developed and defined, it may result in a request for state licensure," he continues, along with a plea for a separate licensing board. "The argument is made that a newly licensed area — in order not to be overridden, forgotten or ignored by the physician — should be controlled by the practitioners who are being licensed," he explains this scenario.

The move for state licensure also is prompted by a need for legal recognition of these groups and their activities, Bumgarner says, for purposes of liability and other types of conflict. And increasingly, state legislators are willing to listen to the arguments of these newly defined groups, as well as to the pleas of those practitioners already licensed who want to update and expand their scopes of practice to meet current trends, demands and activities.

There is no doubt that through the years the skills of the allied practitioners have evolved as the technology evolved.

"The technology is now such that some groups — such as the physical therapists — can do some tasks as well as or even better than physicians," says Dr. Burkhart. "But where all of these allied groups fall way short is in the area of diagnosis," he adds. "These are people who are trained to treat symptoms — not to diagnose disease."

Perhaps the difference between a medical education and a nursing education is best pointed out by someone who has received both. Like Dr. Morgan-Minott, Victoria Ruff has earned both RN and MD designations. "I trained as a registered nurse and received a diploma from Massillon City Hospital," she explains. "I was very active in student nursing organizations. And I thoroughly enjoyed nursing," she recalls.

But like Dr. Morgan-Minott, Dr. Ruff soon discovered that nursing, for her, was not enough. "I realized that I could do a lot more for the patient as a doctor," she says, "and that I wanted to practice medicine. And so I went to medical school."

There, she discovered that a medical education was totally different from nurses' training. "In rather simplistic terms, I would sum up nursing education as being more technical, task-oriented and theoretical," she says. "The time spent in basic sciences is limited. Direct patient care and psycho-social issues are stressed. With advanced nursing education, less emphasis is placed on technique and more on the theory of the practice of nursing."

Medicine, on the other hand, she continues, "is more oriented toward differential diagnosis, decision making and continual integration of a multitude of facts. Its foundation is built on the basic sciences and physiological principles. This process is repeated over and over. Integration of the basics becomes paramount in medical school and resident training and becomes a way of thinking, deducting and, ultimately, decision making. Nurses are not given that sound foundation in basic sciences on which to build their understanding of the mechanisms of disease."

And even if nursing programs were completely revised to include that foundation, the result would do little for health care or the patient — simply duplicating what already is available in medical schools and ignoring what is important in nursing. "The bottom line," says Dr. Clarke, "is if you want to practice medicine, you can always go to medical school."

Today, 33% of all medical school students are women, and the number is growing each year. "If the women's movement has done anything, it has made women more aggressive and willing to do

"There is a general lack of understanding by the public on just how long it takes to educate a physician."

more challenging things," says Dr. Wolfe. "It has allowed women to realize that they are of equal worth and of equal brain capacity — and that they can do as well in any occupation as a man."

So the role of sexism in the traditional physician-nurse relationship is quickly being diminished, says Dr. Wolfe. "Sexism undoubtedly has played a role in some physicians' attitudes toward nurses in the past," she says. "However, the vast increase in the number of women physicians has, to a large extent, mitigated this attitude. I believe the majority of women physicians think and act as do their male counterparts with respect to the nursing question."

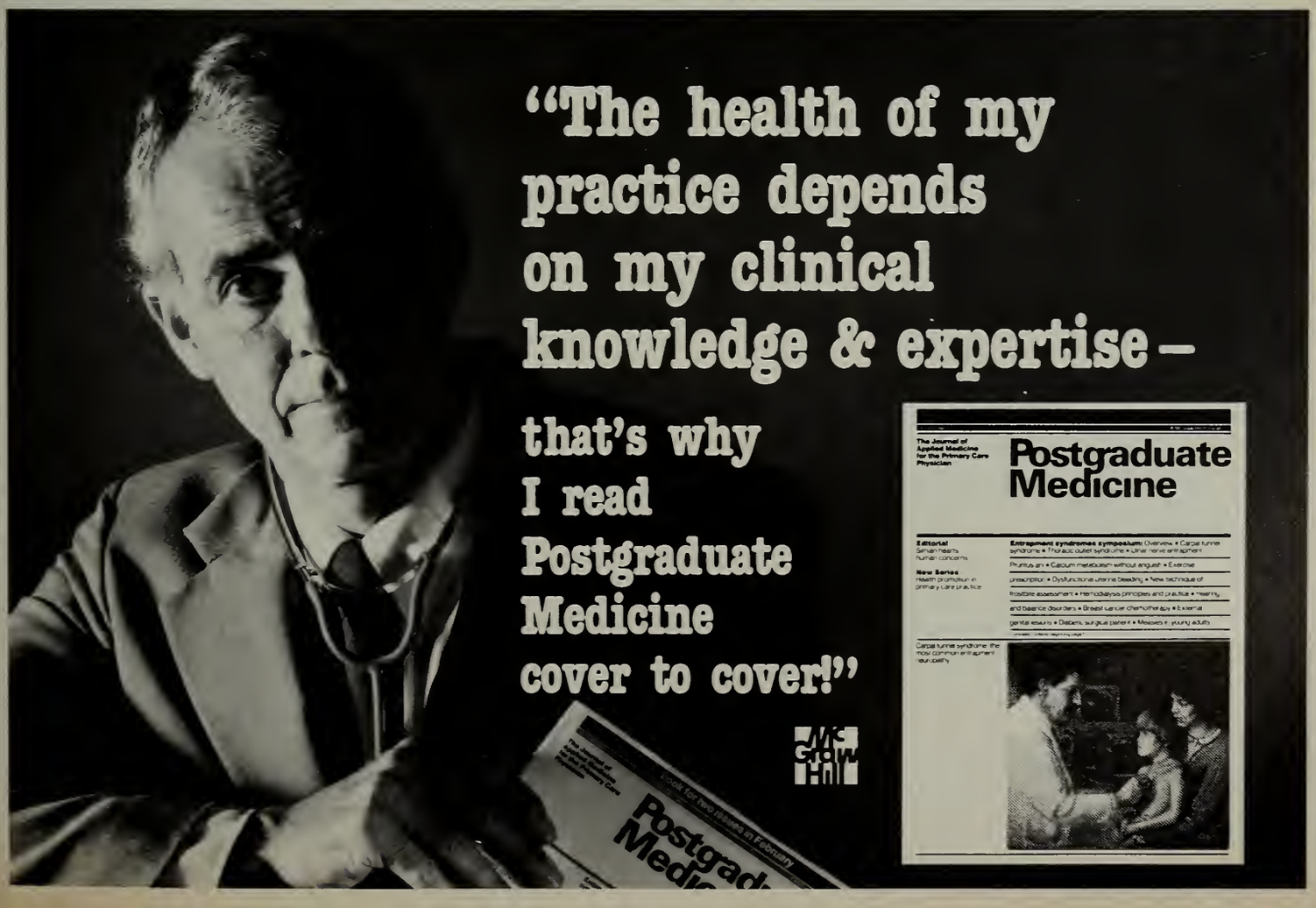
Still, many women and men in non-physician health care roles continue to feel underrated by physicians and want independence. "There is a natural tendency to want to develop professional independence — to do things your own way," Dr. Ruppert says.

"As the allied professionals grow more and more involved and developed in their particular areas of expertise, they no longer feel there is a need for supervision by a physician," says Dr. Clarke. So, nurses, physician assistants, chiropractors, pharmacists, nurse midwives, optometrists, respiratory therapists, radiation therapists and medical technologists continue to plead their cases before the state and the public — and much of what they say falls on sympathetic ears.

One problem, says Dr. Burkhart, is that many physicians do not spend much time with their patients, while nurses, technicians and other allied groups make a considerable effort to make patients feel welcome and cared for. So patients assume that most of the care is actually being provided by the assistants. "There is a general lack of understanding by the public on just how long it takes to educate a physician and all that goes into the background and training. They don't understand the difference between technical skills and education — what's in the brain," says Dr. Burkhart.

"If physicians would at least take a little more time to explain things to their patients, I think the public would show a lot more allegiance," he says.

Yet public opinion polls



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"The physician is the only one with the extensive training and background required to be the patient's best advocate."

continue to show that while patients are happy with their own personal physicians, they have generally negative feelings towards doctors in general. "They see us as money hungry, uncaring and impersonal," says Dr. Burkhart. "And so the other practitioners are taking advantage of this attitude and are seizing on the general public to support their causes."

The real danger in the success of this effort by the allied practitioners, however, lies not in the loss of power, status or income for physicians. Rather, it is the potential development of a disjointed, fragmented health care delivery system that forces consumers to decide which of the numerous health care provider groups will provide the appropriate care.

"Increased independence (by the allied groups) can only lead to increased fragmentation in patient care," says Dr. Ruppert. "For quality health care, you need to have a cooperative venture with a team leader who knows what is best for the overall good of the patient. Even the pre-paid programs, such as HMOs and IPAs, recognize this and require that a physician coordinate the patient's care."

The greatest impetus to the creation of a fragmented system is allowing each allied group not only to don a white coat but also to hang out a separate shingle. "If you have numerous and different entry levels into the health care system — and that system has no mechanism for taking all of the patient's problems into consideration, this will definitely result in poorer care for the patients," Dr. Ruppert says. "An individual could have expertise in one area — but completely miss another and more important area. And one provider may give treatment that is in conflict with what another practitioner is doing."

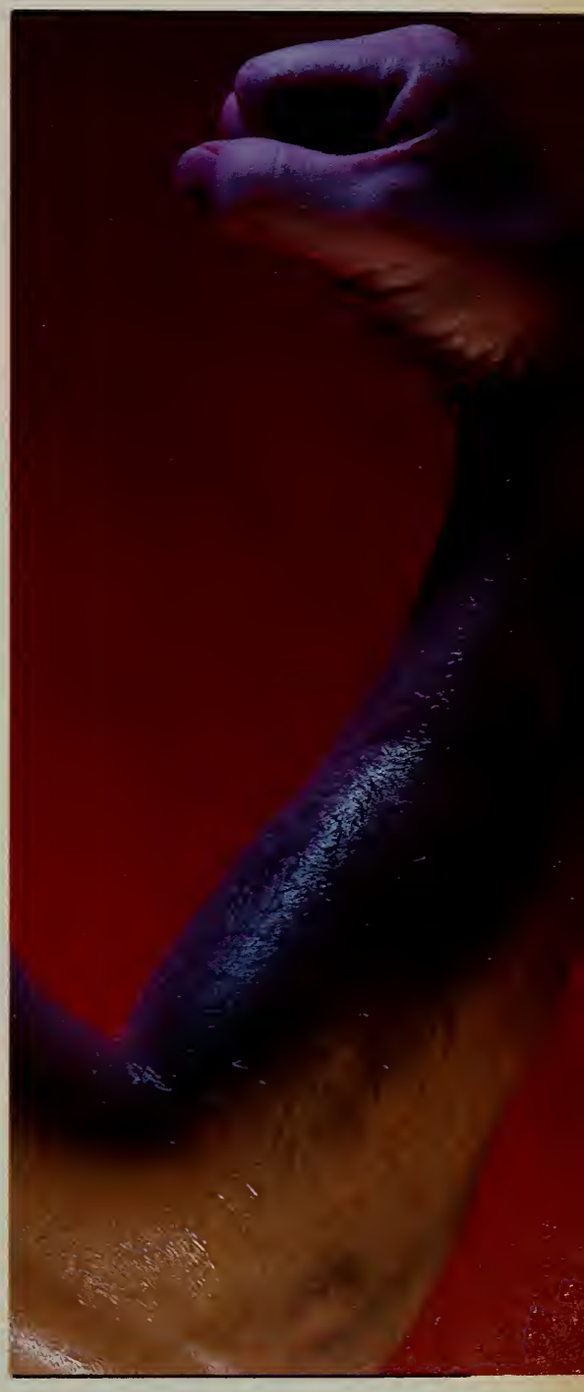
What allied professionals often forget, says Dr. Clarke, is that, in the past, they have always acted under — and relied upon the expertise — of the physician. "Today we have nurses exquisitely trained in intensive care and coronary care looking after our most critical patient at two o'clock in the morning," he says. "But they are there because the physician has set the protocol for them to be there. And the physician is still available to them at all times."

The bottom line, says Dr. Ruppert, is that "we are all here to keep people healthy. But, in order to do that, someone has to remain involved in selecting the right health care for the patient. After all, the physician is the only one with the extensive training and overall background required to be the patient's best advocate."

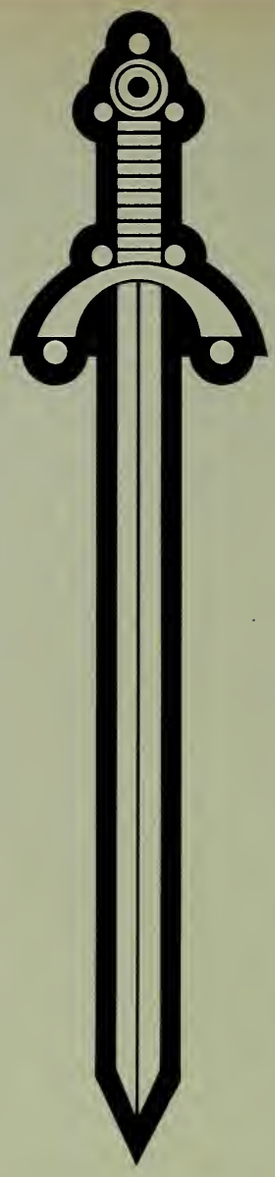
Still, not all of the controversy and conflict going on at the Statehouse is bad, he adds. "Allied professionals certainly have the right to make requests," Dr. Ruppert says, "and these requests must be brought to the table and discussed. This sitting down, re-evaluating and working things out may be a necessary part of the evolution of our health care system today."

And, as long as communication continues, doctors will continue to be able to work in a congenial fashion with nurses, physician assistants, medical technicians, and all of the other members of the health care team.

"It's like a marriage," says Dr. Clarke. "A husband and wife get hung up over some little problem — and they stop talking. And once they stop communicating, the marriage is over. If they can continue to sit down and discuss things, on the other hand, they soon find out that they agree in many more areas than they disagree." **OSMA**



Susan Porter is the Associate Editor of the **Ohio State Medical Journal.**



Rebuilding Camelot

The story of the Commission on Interprofessional Education

By Karen S. Edwards

In a world teeming with new health-care possibilities and rising ethical dilemmas, they envisioned a commission which would unite health-care professionals . . .

It may not be Camelot, but the Commission on Interprofessional Education comes as close to emulating King Arthur's dreams of unity as anything can in the highly specialized, subdivided world of health care.

Historically, interprofessional relationships are nothing new. Doctors have been dining with lawyers, meeting with nurses and powwowing with pharmacists for decades in the interests of "closer work affiliations." But these meetings were usually social in nature, and almost always bilateral in approach. Rarely did more than two interprofessional groups meet together at the same time.

As time continued to spawn new specialties and split others into smaller and smaller parts, however, the need for a larger, more comprehensive interprofessional gathering proved to be overwhelming to Van Bogard Dunn, who was then dean of the Methodist Theological School in Ohio, and Donald Vincent, MD, who was serving as director of Continuing Education at Riverside Hospital in Columbus.

In a world teeming with new health-care possibilities and rising ethical dilemmas, the two envisioned a commission which would unite health-care professionals in much the same way King Arthur used to dream of uniting feuding tribal lords. In both cases, it seemed a necessity.

"The world was becoming more complex, and new problems were arising that had not been dealt with before," says Mary Janata, program director of the Interprofessional Commission. "Instead of a comprehensive health-care service, medicine was becoming more and more fragmented."

So, the two set out to bring the separate parts together.

By the early 1970s, they had been able to bring together multiple specialty groups for a brainstorming session. What came out of this session was the idea for a permanent commission — one which would bring together members of eight "human service" professions to "address collaboratively the complex ethical and social problems encountered increasingly in professional practice."

The Commission became a reality in 1973, with a grant from the Ohio Board of Regents. Support came quickly, and from all directions. Now, the OSU professional colleges and schools, the OSU provost, the Columbus Cluster of Theological Schools, and the state professional associations all give it enthusiastic backing.

But how "real" is the Commission?

Formed under the auspices of a university organization, it could easily be nothing more than an academician's knee-jerk reaction to a collective conscience — full of theories and philosophies but as lacking in substance as Camelot itself.

Fortunately, it's not.

In its 13-year existence, the Commission has not only succeeded in acquainting the professions with each other, but in getting these diverse groups to work — even think — together as a team.

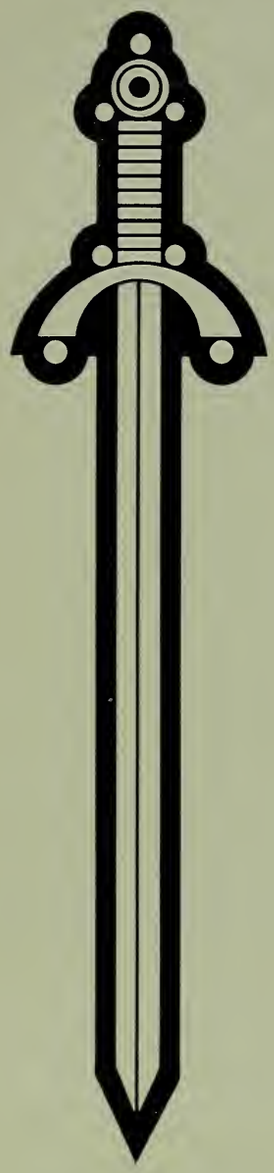
The training starts at the student level.

"The Commission offers interprofessional credit courses to those students enrolled in the human service professions," explains Janata.

A careful balance of nursing students, medical students, social work students, law students, and future educators learn early from an interprofessional faculty team that the world is a big, highly focused place — and that every practice has its limitations.

"Knowing what you can *not* do can be just as important as knowing what you can," says Luvern Cunningham, PhD, an educator and chairman of the Commission's Board.

Course work includes study of:



"Because there are now so many technical advances, the humanities of medicine are becoming more important."

• **Changing Societal Values** — how such social issues as deinstitutionalization, gerontology, genetic screening and chemical dependence affects the professions.

• **Interprofessional Care** — a case study helps students outline interprofessional treatment strategies.

• **Ethical Issues Common to the Helping Professions** — an examination of ethical decision making, professional accountability, issues of life and death, privacy and confidentiality, and informed consent explored both professionally and interprofessionally.

In addition, students may also attend seminars in clinical settings, participate in medical ethics rounds or attend a three-day Summer Institute, featuring timely topics of concern to the professions. (This summer, AIDS will be the topic of discussion.)

All of the courses are currently being offered on an *elective* basis — students can choose to take them or not. According to Janata, however, attendance in these classes is growing at a steady rate, and Cunningham notes that the College of Education is requiring all students studying for administrative positions (e.g. principals) to take the interprofessional course.

That's not likely to be the case in the College of Medicine, however, says Dean Manuel Tzagournis, MD.

"Frankly, medical students are overwhelmed as it is just learning the *science* of medicine," he notes.

But he is quick to point to the importance of what he calls the "humanities of medicine" in a medical school education . . . those courses which involve the history, ethics, law, philosophy and art of medicine.

"Because there are now so many technical advances, the humanities of medicine are becoming more important than ever," says Dr. Tzagournis.

New medical assist devices, for example, are making the determination of death more difficult — and *who* decides who gets an organ transplant?

"The interprofessional courses are teaching students to look at these problems with a broader scope," says Dr. Tzagournis.

But he believes that there is much less "tunnel vision" in the profession now, anyway. Hospital ethics committees are helping to raise consciousness in this area, and, "I think more and more physicians are making use of chaplains and priests in their decision-making process," says Dr. Tzagournis.

Although the interprofessional courses do not yet boast many medical students, Dean Tzagournis has watched enrollment increase steadily, if still a little slowly.

"We have gone from about 12 students to about 30," he says.

He is happy, however, to make certain opportunities, such as grand rounds and the medical ethics grand rounds, available to those outside the school of medicine.

"Before the interprofessional course, these learning experiences were only available to medical students," he says. Now, students from other professions are able to benefit from this unique training ground as well.

But what of those physicians who are already in practice?

That's the second arena in which the Interprofessional Commission has engaged, explains Janata.

"The Commission sponsors two major statewide interprofessional conferences in continuing education a year," she says.

Topics are chosen by a special "continuing education" committee, made up of representatives of the eight state associations which constitute the commission.

"The committee is careful to choose subjects which will address timely interprofessional issues. Generally, they are topics which are not being dealt with by a single profession," she explains.

Death and dying, issues of privacy and confidentiality, interprofessional approaches to stress, aging and genetic screening and counseling have all been part of the Commission's continuing educational effort.

"Our most popular course to date was one on how to maintain a caring relationship in a technological age," says Janata.

Because of physical space limitations at conference sites, attendance at these seminars have been limited to 200-300 participants, though Janata believes the number would be higher if more space was available. As it is, the Commission is able to increase exposure to its conference speakers by repeating the conference a second day on Ohio State University's campus.

"We open the conference to *all* students and faculty members — not just to those in the human service professions," says Janata. Approximately the same number of those attending the first conference — about 200 — turn out to listen to the repeat seminar.

Although the number of participants *could* prove to be unwieldy in attempts at interprofessional group discussion, the Commission has solved that problem the same way King Arthur might have done — by using round tables.

"We find that placing participants together at round tables instantly breaks them up into small discussion groups. We try to keep each group carefully balanced so that everyone has access to the expertise of someone else's profession," says Janata.

The program leaders — usually a team comprised of two or three different professionals — then present a case report for discussion.

The cases are like ethical tongue-twisters — thorny and difficult at first, but manageable the more they are worked on.

"The first thing the participants find themselves having to do is to get rid of the stereotypes they bring with them. Once this is done, they usually find they can work together quite well on these concrete problems," says Janata.

And they learn, she adds. They learn the limitations of the professions, and discover how they can gain access to the knowledge and experience of other professions. They learn to look at the whole problem, rather than its individual parts, and they learn how to integrate treatment solutions. And, perhaps most important, they learn to work together, colleague with colleague.

"This can apply to all physicians — not just to those in an institutional setting. Interprofessional discussions *can* help the individual practitioner as well," claims Janata.

In fact, it is often the individual practitioner who benefits most from the Commission's third arena — the Commission Assembly.

The Assembly acts as a permanent forum of the Commission, and is made up of representatives from professional associations and academic units across Ohio, not normally associated with the Commission — as well as those which are.

The Assembly's job is to analyze interprofessional issues and formulate appropriate public policy in Ohio.

"We are *not* a lobbying institution," Board Chairman Cunningham is quick to point out. "Our Assembly simply makes a collaborative study of the issue, and puts together a policy-informing paper which can be used by the professional associations or by legislators. We don't advocate one position or another. These papers are for information only."

Since the fall of 1983, three of these policy panels have been commissioned — one to study "Alternative Modes of Reproduction," another to examine "Health Care Cost Containment," and another to take a look at "Family Violence."

The points of view represented in these papers accurately reflect the eight different groups which have been involved in the study, says Cunningham.

"And as near as we can tell, the legislators are using them," he adds.

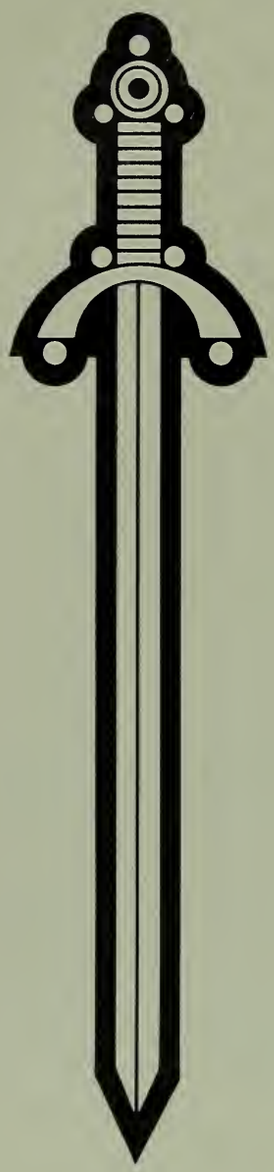
What Cunningham and the Commission are hoping to gain from these white papers is a higher quality of law which will be more useful in mediating the ethical and technical issues which are being raised.

"The Assembly is also the Commission's outreach program," Janata explains. Because it comprises organizations and universities which are not part of the Commission itself, the Assembly serves a viable role in promoting interprofessionalism across the state.

Interprofessionalism is something which may not need much future promotion, however.

"The concept is already building up steam," Janata points out.

Hospital ethics committees have



"No one professional discipline has all the answers. We need to work together to solve problems that can't be solved individually."

already been used as an example, but there are others as well.

For example, Dr. Vincent, now director of Riverside's geriatric unit, has set up his unit at Riverside to follow the same interprofessional criteria used by the Commission. And Charles E. Wilkens, MD, director of the geriatric department at St. Elizabeth Hospital in Youngstown, is conducting a similar interdisciplinary program in his unit, thanks to a one-year Special Initiative Award granted by the Department of Health and Human Services and developed in conjunction with Youngstown State University and the Northeastern Ohio Universities College of Medicine. Case Western Reserve University in Cleveland has also dabbled with interdisciplinary education, but in a paper "Experiments in Collaborative Education," written by Doris Modly, RN, with Patricia Noderer, RN, and Lloyd Ellis, MD, reasons are given as to *why* Case Western never developed a *permanent* credit course:

"Such interdisciplinary programs frequently have been funded by outside sources, and when these resources are depleted, the programs are discontinued because professional schools do not find it cost effective to support courses not required of all students or by licensing boards. This is the case with previous collaborative efforts at Case Western Reserve University. An elective, interdisciplinary clinical course was discontinued after six years of relative success and in spite of the high value placed on such learning activity by students and faculty as well."

"That's what makes the Interprofessional Commission so unique," says Janata.

Although financial backing originally came from a university source, funding sources have grown — not diminished. Participating colleges at Ohio State, the office of Academic Affairs, related state professional associations (the OSMA contributes $1000 a year to the Commission), and grants from the W.K. Kellogg Foundation and the Columbus Foundation have made the Commission stronger — and able to take on new responsibilities.

For example, its latest effort has been directed at creating a national commission.

"Last fall, we visited the national headquarters of those professional associations affiliated with the Commission to see if there was any interest in a national commission," says Janata.

There was. Immense interest. Each organization the Commission visited agreed to send a representative to a national planning symposium which was held last December.

Oscar Clarke, MD, Gallipolis, was the AMA's representative.

"Because society has become so complex, issues now *require* a multidisciplinary approach," he says. He points to surrogate mothering as an example of one of today's problems that need collaborative attention.

"Look at all the different aspects this subject has. There is a social side, because it involves people; there is certainly an element of religion, because mortality questions are raised. Then, there is the legal side. What rights do surrogate mothers and their offspring have? And who is liable should things not go as planned? And, of course, there is the medical side. No one professional discipline has all the answers. We need to work

together, jointly, to solve those problems that cannot be solved individually," he says.

That requires integration of disciplines and the ability — as well as the willingness — to communicate with each other.

Of course, that willingness *could* be as difficult to obtain as Camelot was to unite. Few would argue that, traditionally, there have always been boundary lines around each of the professions, creating little "turfs" where trespassing rarely — if ever — occurred.

But time is smudging the lines, and those associated with the Commission say that they have seen little "turf-guarding" by professionals these days.

"Once it is explained to the professional — once they understand *why* the action has been taken, or why it is needed, they don't argue. If anything, they become crusaders — champions of the interdisciplinary approach," says Dr. Clarke.

"I've not noticed any turf battles at our seminars," agrees Cunningham. "Everyone works together."

The fact that the Commission is neutrally housed and is equally owned by *all* the professions may account for some of this general willingness to relax age-old boundaries, says Janata.

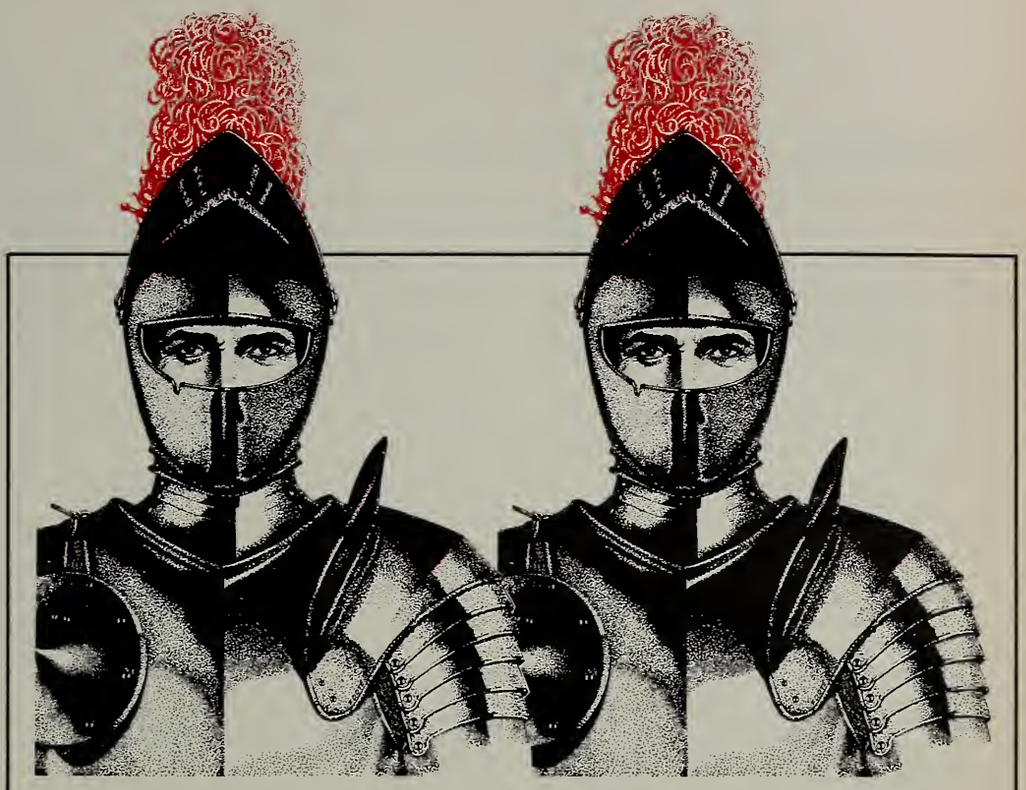
"But in all of our discussions, there are no hierarchical manifestations. The problems we deal with transcend any guarding of turf," she adds.

The December meeting proved fruitful. The representatives who came agreed, enthusiastically, that a national interprofessional commission was an idea whose time had come. They will return to Ohio State University's campus this spring for a planning meeting — to decide how best to set up such a national commission.

In doing so, it is perhaps fitting that representatives come to *Ohio*. As OSU's President Edward Jennings said in his speech to the group this December:

"You have come . . . from around the state of Ohio or across the nation to consider an important and innovative idea — the creation of a national organization to foster interprofessional education and practice. In considering this question, you are building upon the work already done here in Ohio.

"There is tremendous value to the interprofessional approach. It fosters connections between scholars and practitioners, between the university and society, and



Knights of the Round Table

Camelot had its "Knights of the Round Table." The Commission on Interprofessional Education and Practice has its member associations and organizations. These include:

- The Ohio State University
  - — College of Education
  - — College of Law
  - — College of Medicine
  - — College of Social Work
  - — Mershon Center
  - — School of Allied Medical Professions
  - — School of Nursing
- The Columbus Cluster of Theological Schools
  - — Methodist Theological School in Ohio
  - — Pontifical College Josephinum
  - — Trinity Lutheran Seminary
- Ohio Chapter, National Association of Social Workers
- Ohio Council of Churches
- Ohio Education Association
- Ohio Nurses Association
- Ohio Psychological Association
- Ohio Society of Allied Health Professions
- Ohio State Bar Association
- Ohio State Medical Association
- The Academy of Contemporary Problems.

Like their round table counterparts, each member association works diligently for the benefit of all the disciplines and, ultimately, for the betterment of patient care. — *Karen S. Edwards*

Rebuilding Camelot . . . *continued*

among the professions. It allows us to examine complex social and ethical issues in the light of these diverse — and sometimes conflicting — viewpoints. The potential contribution not only to the professions and to the academic world, but also to the formation of public policy is enormous."

The interdisciplinary approach to health care *is* a coming trend, says Dr. Clarke.

It is an approach that will go "on into the future" as a general interest in ethics and the medical humanities becomes more prevalent, agrees Dr. Tzagournis.

"The Commission has had a positive impact on the professions," says Janata. "It *extends* the disciplines; it doesn't force them to compete."

And that extension of discipline is exactly what is going to be needed by tomorrow's patient as health care becomes more technical and more complex.

In creating Camelot, King Arthur was ahead of his time.

In creating the Commission on Interprofessional Education and Practice, maybe health care is *just* in time.

For more information regarding the Commission, its goals, practices, membership or publications, please call or write:

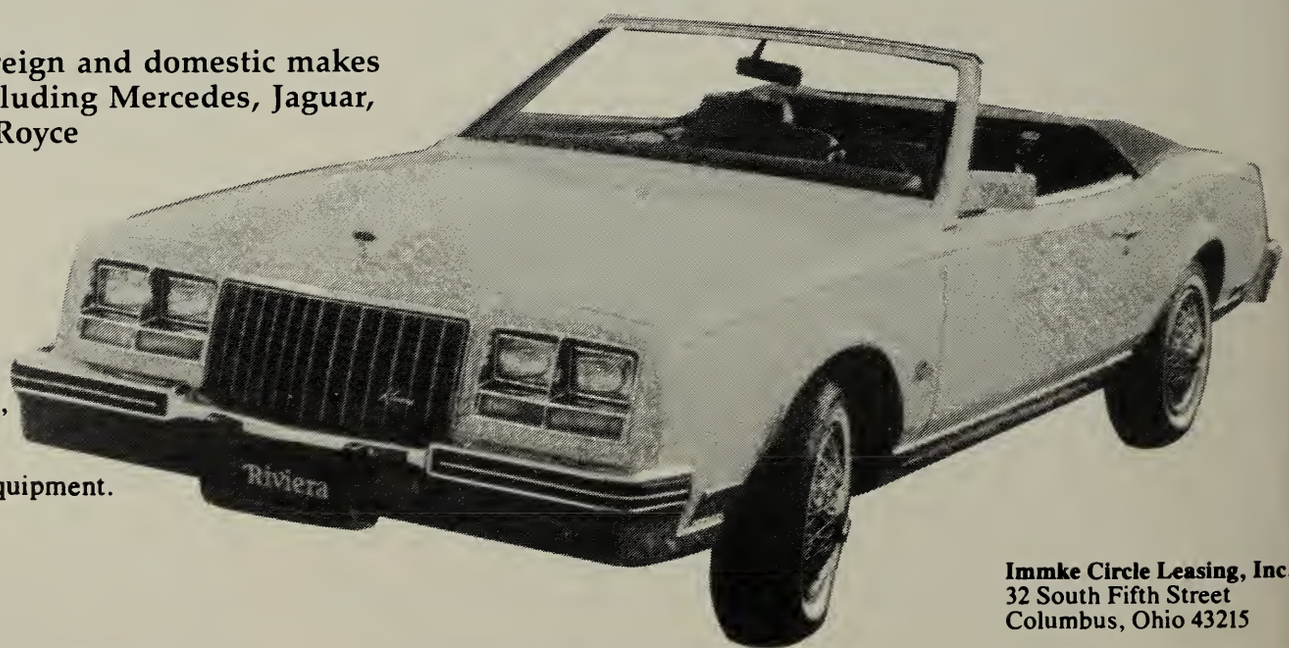
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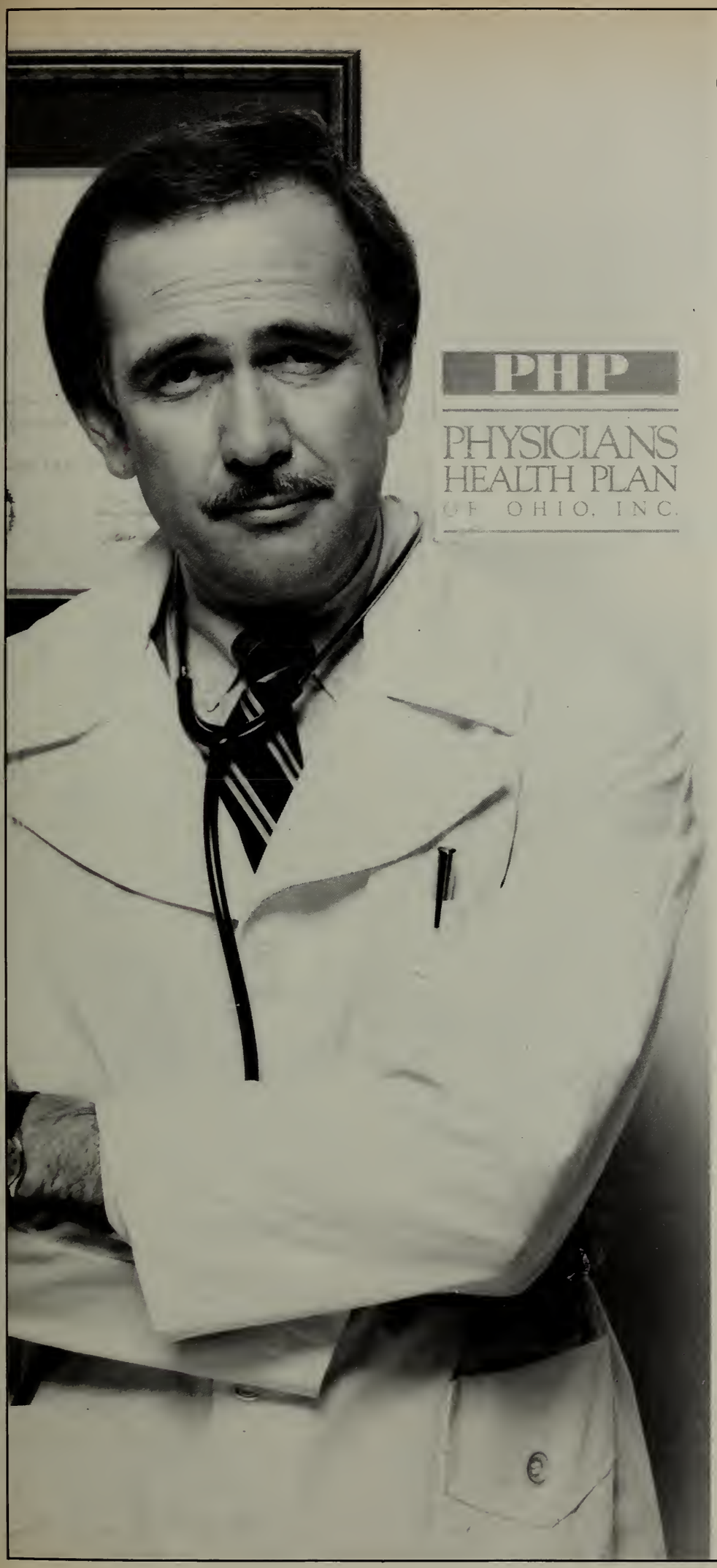
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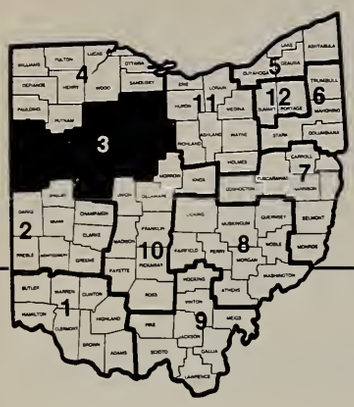
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Councilor Commentary

Third District

Thomas R. Leech, MD

"All through the '70s, the image of the physician was slipping — I knew we had to do something about it," says Thomas R. Leech, MD, Third District Councilor of the Ohio State Medical Association.

That explains why Dr. Leech, a plastic and reconstructive surgeon in Lima, Ohio, continues to regard public relations as such an integral element of organized medicine.

Over the years, Dr. Leech has made it a priority to get involved in the communications aspect of his profession. He has served as chairman of the OSMA's Communications Committee, and, more recently, as a guest physician on a bimonthly television series in Lima. The program allowed him to speak directly to the public about a variety of informative and timely medical topics.

Both of these experiences have given Dr. Leech the opportunity to hone his expertise as a communicator — a quality which comes in handy in his role as OSMA councilor.

After receiving his medical degree from the University of Pennsylvania School of Medicine in 1951, Dr. Leech interned at St. Luke's Hospital in Cleveland. From 1952-1957, he completed his general surgery and plastic surgery residencies at the Ohio State School of Medicine in Columbus.

In 1957, Dr. Leech set up his private practice in Lima and, shortly thereafter, began his involvement in organized medicine. He has been alternate delegate and delegate to the OSMA, and president of the Allen County Medical Society, and is a member of a number of organizations, including the American Medical Association and the American Cleft Palate Association.

"Medical leadership is necessary to protect the ideas and ideals of medicine."

Currently, Dr. Leech is finishing his second term as councilor for the Third District — an area encompassing 11 counties, including Allen, Auglaize, Crawford, Hancock, Hardin, Logan, Marion, Mercer, Seneca, Van Wert, and Wyandot.

Lima, located in Allen County, is the "drawing center for the district," according to Dr. Leech. The two major hospitals there, Lima Memorial and St. Rita's Medical Center, attract a general population of over half a million people, he estimates. Dr. Leech is on the active staff of both hospitals.

One reason for Lima's magnetism, its attraction, is that a number of specialists have located there, Dr. Leech points out, adding that the Lima area is now home to about 150 physicians.

This "essentially rural" district is no stranger to some of the changes occurring in the medical field today, including the emergence of alternative care delivery systems.

"The physicians in Allen County are currently in the process of setting up a physician-controlled HMO-IPA." But this kind of competition — at least right now — is still in the early stages. It's not a trend that's sweeping through the area, but rather touching down here and there — so it's more of a concern, than a real problem.

For example, some physicians are concerned that, eventually, they will lose patients to HMOs, as more and more people will be

enticed into HMOs through their jobs.

These are legitimate concerns, Dr. Leech says, though he maintains that "there is room for all forms of medical practices, in one context or another — whether it's fee-for-service, the 9-to-5 clinic or an HMO."

For one thing, he points out, it's difficult for young people coming out of medical schools to launch their own private practices. Sometimes, in order to pay their debts, the clinic is the safest route.

In any case, Dr. Leech leans toward the probability that the "pluralistic system of medical care is going to prevail." This means that these various types of practices will have to coexist.

Since their inception, alternative delivery systems have incurred a variety of criticisms from opponents who assert that HMO patients will receive a decreased level of medical care — care that is more commercial and less personal.

There is a *potential* for decreased quality of care in *some* circumstances," Dr. Leech says. But it's not a probability, he adds — just a possibility.

Another concern facing physicians in the Third District — as in other areas of the state — is the malpractice issue. Basically, it's a question of, "Why do I have to pay so much for my insurance?" he explains.

"A litigious society with a trend toward excessive awards and an increased number of attorneys creates this kind of detrimental atmosphere," he offers in way of explanation.

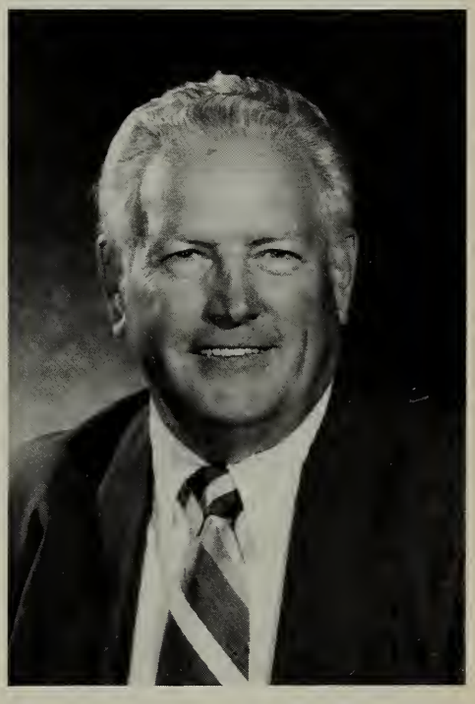
There has to be some kind of tort reform to ease the climate, he says. "The OSMA is taking a lead in this issue, through Dr. Henry and the Task Force on Professional Liability," he adds.

The introduction of DRGs and their ultimate effect on the quality of patient care have also created some controversy in his area. "At this time, there is no concrete evidence that any money is being saved" with the DRG system, Dr. Leech points out.

Still, he cautions that with this concern and others, reality dictates a "wait-and-see" attitude. In the meantime, it's important that physicians band together to guarantee that the eventual outcomes of these issues are beneficial for patients and physicians alike. "We must have an organized front" if we are going to modify these issues, he says.

Then, he capsulizes the importance of involvement in the OSMA and organized medicine in more simple terms: "Medical leadership is necessary to protect the ideas and ideals of medicine."

— *Deborah Athy*



Thomas R. Leech, MD



Councilor Commentary

Twelfth District

Joseph L. Kloss, MD

Shortly after completing his pediatric residency at Akron's Children's Hospital in 1960, Joseph L. Kloss, MD, 12th District Councilor for the OSMA, began what was to be a continuing and diversified association with organized medicine.

Locally, he was appointed chairman of the Infectious Disease Committee at Akron's Children's Hospital and of the Pharmacy Committee at Saint Thomas Hospital in 1964-65. Several years later, he was elected president of the Akron Pediatric Society and of the Children's Hospital Alumni Association.

His involvement at the state level, however, took a little longer to get rolling. For one thing, "I didn't know a lot about the state organization at that time," he admits. And, in addition, "back in the '60s, to a group of us who were new at practice, it seemed that the same people were always running" — and being elected — at the state level.

But what he soon discovered — once he decided to get involved — was that organized medicine was as accessible at the state level as it was locally. He was elected alternate delegate to the OSMA in 1970; and, two years later, was elected delegate — a position he's held ever since.

"That first trip down to Columbus was interesting," he recalls. "Interesting enough that when the time came up for re-election, I was happy to run again."

All during this time, Dr. Kloss, who received his MD degree from the St. Louis University School of Medicine in 1957, continued his initial commitment to organized medicine on the local level: as president of the Summit County Medical Society in 1970; secretary-treasurer of the Medical Staff at Children's Hospital, 1971; chairman of the Medical Records Committee, 1970; and chairman of the Public Health Committee, 1970.

It was about this same time, too, that Dr. Kloss, who had been practicing pediatrics for about 12 years in Akron, began pursuing his interest in dermatology — an interest that had started years before. He completed a dermatology residency at Cleveland Metropolitan Hospital, and is now an Akron dermatologist and assistant professor of dermatology at Northeastern Ohio University College of Medicine. He is also the director of the Department of Dermatology at Children's Hospital.

Fifteen years ago, "fee-for-service was the norm . . . that was it." Now the number of physicians going into solo practice is substantially smaller.

Dr. Kloss is now in his third term as OSMA Councilor for the 12th District. The area he represents is "actually the smallest, geographically, and the youngest," he says. Just two counties make up this district: Summit, which is home to about 600 physicians in mostly "urban" practices; and Portage, which has about 100 "multi-practice" physicians.

There are four large hospitals located in Akron, the heart of Summit County, Dr. Kloss says. Consequently, for physicians, this area tends to be very hospital-oriented. For example, there seems to be "a basic nucleus of physicians in each hospital which only uses that hospital's services," he explains.

Another prevalent trend operating in Akron at present is the prominence of group practice networks. "Some physicians are going into group practices, not because they particularly like the concept, but because they don't see any way around it," Dr. Kloss points out. "They're afraid not to or else they think they're going to lose some of their patients," he adds.

To a large extent, this is a valid concern, Dr. Kloss says, because some patients are being enticed to join various alternative delivery systems through their employers.

Consequently, "more physicians than not have joined up with more groups than they need to."

More and more, this "jump on the bandwagon" attitude is prevailing — in the 12th District as well as other areas of the state. Several HMOs are operating in Akron — such as the Akron Clinic — and a number of others are said to be coming in, Dr. Kloss says. In addition, all of the hospitals have joined PPOs, and for-profit organizations and urgent care centers are on the increase.

So, just as Akron itself has changed — from a city whose workforce once comprised a high percentage of tire factory workers to a city that is now largely white collar — the medical environment has also undergone transformations.

Fifteen years ago, "fee-for-service was essentially the norm . . . that was it," Dr. Kloss recalls. Now, the number of physicians going into solo practice — while not approaching extinction — is substantially smaller than it used to be.

"The competition is certainly a major factor for all of the physicians in this district," Dr. Kloss points out. And, as the number of physicians grows, the competition grows, he adds.

Still, even though "there is that sense of underlying rivalry and competition . . . it's not vicious," he says. And, what's more, steps are being taken to help ease the competitive atmosphere and to bring physicians together.

The Summit County Medical Society, for example, has formed a "physician-controlled IPA in an attempt to tie together the physicians of the county into a more common group," and to erase those boundaries formed by the different hospitals and medical groups, says Dr. Kloss.

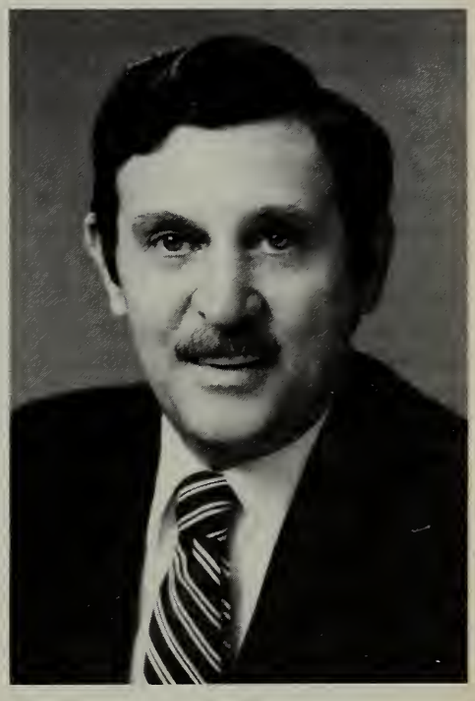
And, since the local medical society has a strong membership, it is able to offer its members a variety of services, such as a meeting hall, a printshop, and a referral service for both patients and physicians.

There is also a special community program to help those patients who, although not eligible for welfare, are unable to pay for medical treatment, says Dr. Kloss. "A number of doctors will see these patients and accept whatever they are willing to pay," he explains.

But these services wouldn't exist, couldn't exist, without a price. The bottom line, here, is dues dollars. "When there's a loss of dues dollars, it's hard to provide services," says Dr. Kloss.

That's why a strong membership in organized medicine is so important, he points out. "When local membership falls, state membership tends to fall" — and that translates into a loss of dues dollars.

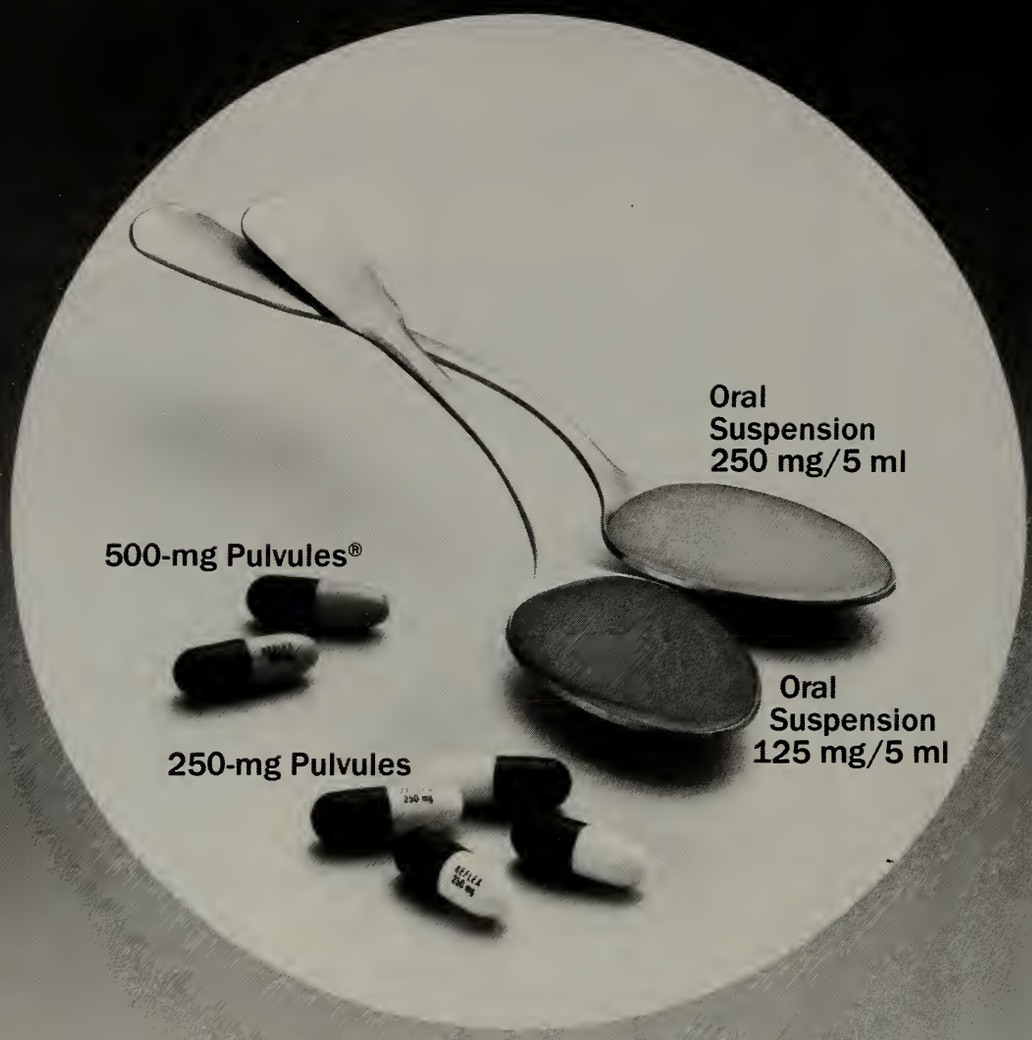
And it's not just enough for physicians to join their specialty societies or local societies. "Physicians should be members of their respective local, state and national organizations," Dr. Kloss advises; because, in the long run, "specialty societies can only do so much."



Joseph L. Kloss, MD

And, when all is finally said and done, he adds, what medicine really needs is a "unified organization that can speak for physicians as a whole." — *Deborah Athy*

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Obituaries

RUTH BENNETT, MD, Chillicothe; University of Cincinnati College of Medicine, 1942; age 69; died December 31, 1985; member OSMA and AMA.

JACK R. BONTLEY, MD, Columbus; Ohio State University College of Medicine, 1948; age 78; died December 31, 1985; member OSMA and AMA.

HENRY D. BROWN, MD, Toledo; University of Cincinnati College of Medicine, 1924; age 86; died December 19, 1985; member OSMA and AMA.

EDWARD P. CALL, MD, Xenia; Yale University School of Medicine, New Haven, Connecticut, 1959; age 52; died December 16, 1985; member OSMA and AMA.

LOWELL DILLON, MD, Holmes Beach, Florida; Ohio State University College of Medicine, 1941; age 73; died December 5, 1985; member OSMA and AMA.

JOHN P. EICHHORN, MD, Lakewood; University of Michigan Medical School, Ann Arbor, Michigan, 1938; age 73; died December 2, 1985; member OSMA and AMA.

GEORGE W. FETZER, MD, Cleveland; Ohio State University College of Medicine, 1930; age 82; died December 3, 1985; member OSMA and AMA.

LOUIS HAIT, MD, Phoenix, Arizona; Eclectic Medical College, Cincinnati, 1938; age 70; died November 23, 1985; member OSMA and AMA.

PERCY L. HARRIS, MD, North Canton; University of Rochester School of Medicine, Rochester, New York, 1929; age 89; died November 30, 1985; member OSMA and AMA.

JEAN K. HOLLISTER, MD, Toledo; Medical College of Ohio at Toledo, 1983; age 27; died December 10, 1985; member OSMA and AMA.

ADIB KARAM, MD, Akron; Case Western Reserve University School of Medicine, 1930; age 82; died December 29, 1985; member OSMA and AMA.

JOHN E. KLINGE, MD, Massillon; Ohio State University College of Medicine, 1935; age 77; died December 31, 1985; member OSMA and AMA.

DOMINIC A. LANESE, MD, Cleveland; Case Western Reserve University School of Medicine, 1922; age 88; died December 3, 1985; member OSMA and AMA.

EDWARD E. LAO, MD, Parma; College of Medicine National Taiwan University, Taipei, Taiwan, 1972; age 38; died November 28, 1985; member OSMA and AMA.

MAURICE F. LIEBER, MD, Naples, Florida; Johns Hopkins University School of Medicine, Baltimore, Maryland, 1938; age 74; died December 31, 1985; member OSMA and AMA.

DAVID LUBIN, MD, Gates Mills; Ohio State University College of Medicine, 1927; age 82; died December 13, 1985; member OSMA and AMA.

JAMES J. MAREK, MD, Fairborn; Eclectic Medical College, Cincinnati, 1927; age 86; died December 2, 1985; member OSMA and AMA.

MEYER N. MARGOLIS, MD, Cincinnati; University of Cincinnati College of Medicine, 1938; age 73; died December 15, 1985; member OSMA.

JOHN W. MARTIN, MD, Cleveland; Harvard Medical School, Boston, Massachusetts, 1934; age 77; died November 28, 1985; member OSMA and AMA.

ESTHER C. MARTING, MD, Washington, DC; University of Cincinnati College of Medicine, 1933; age 77; died November 21, 1985; member OSMA and AMA.

ELLIOT MIGDAL, MD, Akron; Chicago Medical School, Chicago, Illinois, 1949; age 60; died December 1, 1985; member OSMA and AMA.

WILLIAM PERRY, MD, Cleveland; Harvard Medical School, Boston, Massachusetts, 1928; age 83; died December 22, 1985; member OSMA and AMA.

CHARLES S. ROSEN, MD, Ardsley, New York; University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, 1922; age 88; died December 16, 1985; member OSMA and AMA.

WARREN W. SMITH, MD, Columbus; New York University School of Medicine, New York, New York, 1948; age 59; died

Obituaries . . . *continued*

January 1, 1986; member OSMA and AMA.

GRAYDON D. UNDERWOOD, MD, Laguna Hills, California; Ohio State University College of Medicine, 1930; age 83; died October 6, 1985; member OSMA and AMA.

EDWARD L. VOKE, MD, Akron; Ohio State University College of Medicine, 1925; age 87; died December 25, 1985; member OSMA and AMA.

RICHARD C. ZBORNIK, MD, Amherst; University of Cincinnati College of Medicine, 1955; age 56; died December 2, 1985; member OSMA and AMA.

We're Looking for Contributors . . .

There are a number of ways in which you can make the *Ohio State Medical Journal* a more meaningful and useful publication — both for yourself and your colleagues.

For example, do you have an opinion you would like to express? Our "Second Opinion" column is always looking for authors who are willing to take a stand on an issue — any issue.

Or maybe you agree or disagree with something you've read recently in our publication. Our "Letters to the Editor" section would be a good place to state your own ideas on the subject.

Have you recently completed a new research project or finished a scientific study? Maybe your colleagues would like to know about it. Our editorial advisory board welcomes clinical and scientific submissions — especially those which would appeal to our broad range of physician readers.

Or maybe you have expertise in one of our socioeconomic topics for 1985, and would like to submit a relevant article, or discuss an idea for one with our editor. We'd be happy to listen. This year's topics are:

JUNE — New Hope for the Terminally Ill

JULY — Addictionology: Medicine's Newest Specialty

AUGUST — Annual Meeting Round-up

SEPTEMBER — Continuing Medical Education: Do We Need It?

OCTOBER — Are You Practicing Preventive Medicine?

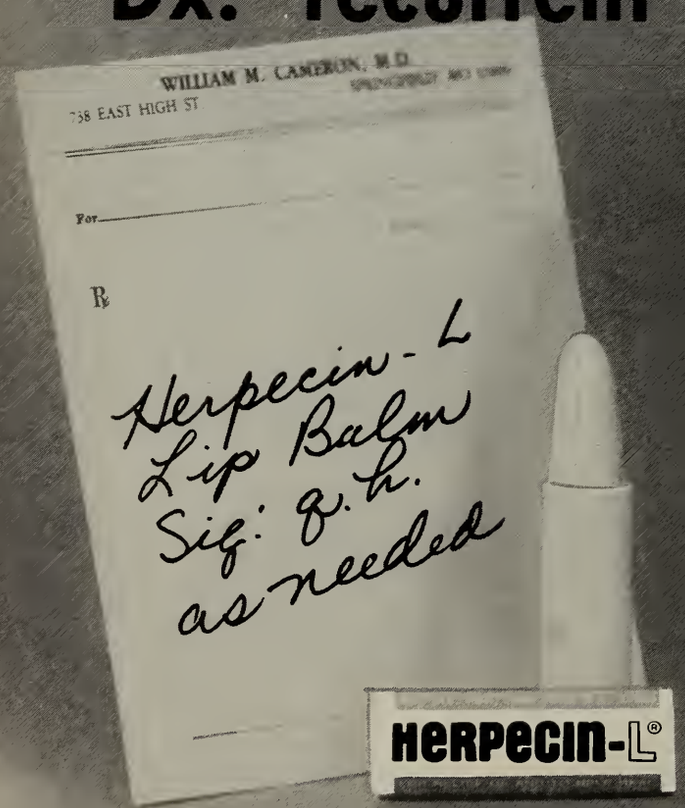
NOVEMBER — Problems Facing Ohio's Hospitals: How Do They Affect You?

DECEMBER — Third-Party Reimbursement

And if you just want to write about something that is meaningful to you, and probably your colleagues — that's what our "Essay" section is all about.

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No Free Lunch

By John E. Sestina

SMB Financial Planning,
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One of the questions a prospective client most frequently asks is why he or she would pay a fee for financial planning services. Even if they agree they should pay a fee they often fall victim to the misunderstanding of terminology regarding financial planning charges: "Fee only," "Fee basis" or "Commission only."

TERMINOLOGY. "Fee only" means the planner receives absolutely *no* compensation other than the fee he or she is paid by the client. The spouse does not own an insurance agency, the child is not a broker-dealer in securities, the planner does not receive a kickback or a piece of the deal.

"Fee basis" can mean there is a fee and should the client "need" any product, he or she can purchase it through the financial planner.

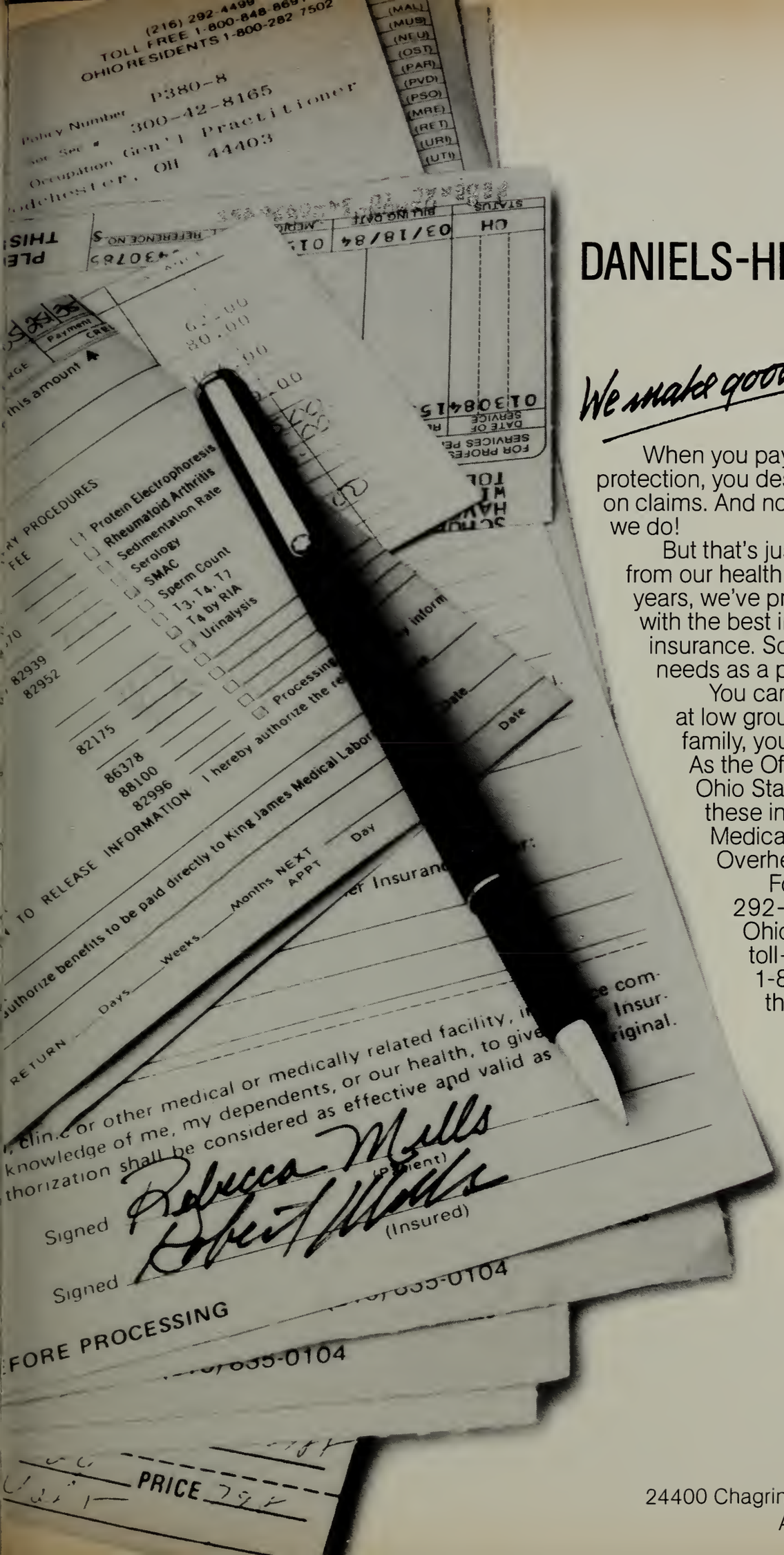
"Commission only" obviously means the planner will sell the client the products he or she recommends.

OBJECTIVITY. The question then is which is the most cost effective for the client. Assuming equal quality and expertise, the difference from the consumer's viewpoint is considerable. It is possible that the consumer "may" receive objective advice from a commission-oriented planner, if the consumer has had the good fortune to find one who truly puts the client's self-interest above the planners. With the "fee only" planner, the consumer is assured of objective advice as the planner has no incentive to steer a decision towards a particular product. This assures the client that any prejudices the planner may have are not formed out of self interest.

SAVINGS. The "fee only" planner can advance the client's best interests by finding low-load or no-load investment products that put a greater share of the client's dollars into productive investment. The commission-based planner cannot do so. Even if the commission-based planner *could* do so, there would be no incentive.

The "fee only" planner is an advocate for the client in a way no commission-based planner can hope to be. The "fee only" planner may negotiate with other financial service professionals on behalf of the client to lower investment commissions and fees, to add investment features that would protect a client's financial interests, and to provide full disclosure on matters of interest to the client. In addition, they can help the client objectively understand the information that may be disclosed in the documents that must be signed. Often fee-based documents disclose the fact that the planner is going to be further compensated, but the information is not obvious to the client. After all, it is not in the interest of the commission-based planner to discuss in detail what is disclosed. If this information *were* clear to the client, he or she may be surprised at how hidden costs can drive up the price of doing business with this planner. The "fee only" planner is also in a unique position to buffer the client from the generally high-pressure, sales-oriented investment world, saving the most precious commodity the client possesses — TIME.

SERVICE. Assuming the planner is a good business person and wishes to earn a substantial income, the majority of his or her time will be devoted to that effort which is most financially productive. In commission-based planning, the more the planner is able to place products, the more financially rewarding it is. Therefore, it is reasonable to assume that major efforts by commission-based planners will be toward the discovery and placement of product to client. However, other important areas in the client's financial life may suffer as a result. For example, what happens after the investment is purchased? Since commissions are generally paid in the first year, the planner will have to continue to place new products to earn a living. Then, where is the financial incentive to productively monitor the *old* investments? The



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commission-based planner cannot earn enough in future years without charging substantial fees. So, the commission-based planner focuses attention on generating a high number of new clients, because new clients tend to be in greater need of new investment products, and will be convinced to invest large sums through new financial plans.

The "fee only" planner, on the other hand, finds a long term relationship to be the most important part of business. A high influx of new clients is generally not needed to keep the business going, so he or she is free to devote creative time to clients, as well as monitoring old deals on their behalf. Any client who has ever invested knows that the honeymoon with an investment can come quickly to an end. But when is the best time to get out of a deal and how should the deal be aborted? By careful monitoring, the "fee only" planner can help solve these dilemmas for the client.

LIMITED OPPORTUNITIES. The commission-based planner has no incentive to find low-load or no-load investments for the client. Further, there is no incentive to recommend a product or investment he or she does not represent. As a result, opportunities for finding the best investments are somewhat limited by these planners. They may miss some good opportunities because they are, in fact, in competition with the person putting together the deal. This limitation results in a disservice to the client.

The "fee only" planner, on the other hand, is motivated to find the most cost effective investment for the client. Since they are not in competition for the commission, they are more likely to be approached by all opportunities.

COST. Because the "fee only" planner's total cost is in the form of a fee, he or she is often perceived as being more expensive than the commission-based planner. However, the client often neglects to see the commission-based planner's "hidden fee." For example, each time a client is told to invest $10,000, he or she pays the commission-based planner $1,500 (assuming a normal commission rate of 15 percent). After only two such investments, the client would have paid $3,000 to the planner, *plus any fee* the planner may have quoted at the outset of the relationship. Let's assume the client was originally quoted a $500 fee. When total costs are added up, it's discovered that the client paid the commisson-based planner a total of $3,500 compared to the "fee only" planner's straight fee of $3,000.

DEDUCTIBILITY. In addition, the client actually paid even more for the commission-based services due to lack of tax considerations. Fees are deductible while commissions are not. The Internal Revenue Service, under Section 212, ruling 73-13 (IRS Bulletin 73-2), states that fees for investment advice are deductible.

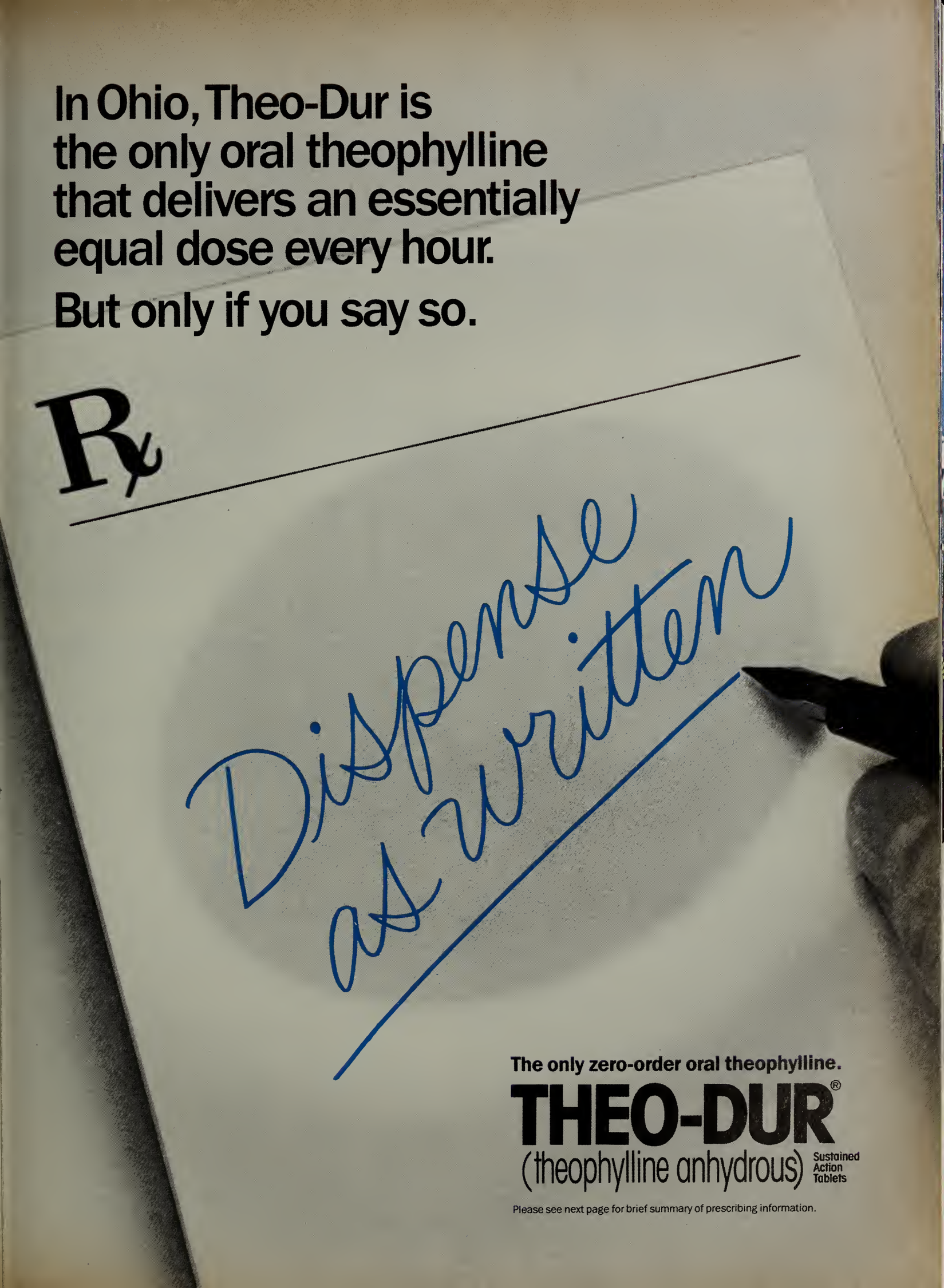
LOSS OF RETURN. Another hidden cost of commissions is the loss of capital working for you. An illustration may help. Assume a client purchases a load mutual fund with $10,000. A typical commission might be 8½%. As a result, the client now has $9,150 working for him. The other $850 goes to the planner as commission. Had the client purchased a no-load fund, the entire $10,000 would have been invested. Ten years later, if each fund grew at 10% per year, the load fund would be worth $23,735, while the no-load fund would be worth $25,939. This results in an actual capital loss of $2,204. In twenty years the loss grows to $5,700. This hidden cost, multiplied by every investment and product purchase made by the client over many years, can result in a dramatic reduction in total available investment value in future years.

We hope this article will help you make a more informed decision when selecting your financial planning advisors. If nothing else, it should confirm again that there is no such thing as a free lunch. **OSMA**

John E. Sestina holds the professional designations of Certified Financial Planner (CFP) and Chartered Financial Consultant (ChFC). He is a member of the Institute of Certified Financial Planners, the International Association for Financial Planning, and is among the select group of professional financial planners to be admitted to The Registry of Financial Planning Practitioners. Mr. Sestina currently serves as Board Chairman for the National Association of Personal Financial Advisors, and is Vice-President of SMB Financial Planning, Inc. SMB is a member of the PICO Financial Services Group which provides specialized financial planning services to physicians and other professional individuals and corporations.

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Indications: THEO-DUR is indicated for relief and/or prevention of symptoms of bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Contraindications: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the tablet components.

Warnings: Excessive theophylline doses may be associated with toxicity; serum theophylline levels should be monitored to insure maximum benefit with minimum risk. Incidence of toxicity increases at serum levels greater than 20 mcg/ml. High blood levels of theophylline resulting from conventional doses are correlated with clinical manifestation of toxicity in: patients with lowered body plasma clearances, patients with liver dysfunction or chronic obstructive lung disease, and patients who are older than 55 years of age, particularly males. There are often no early signs of less serious theophylline toxicity such as nausea and restlessness, which may occur in up to 50% of patients prior to onset of convulsions. Ventricular arrhythmias or seizures may be the first signs of toxicity. Many patients who have higher theophylline levels exhibit tachycardia. Theophylline products may worsen pre-existing arrhythmias.

Precautions: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hourly or sometimes 8 hourly intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.

Usage in Pregnancy: Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthines to a mother who is nursing, taking into account the risk-benefit of this therapy.

Pediatric Use: Safety and effectiveness of THEO-DUR administered every 24 hours in children under 12 years of age, and every 12 hours in children under 6 years of age, have not been established.

Adverse Reactions: The most consistent adverse reactions are usually due to overdose and are:

Gastrointestinal: nausea, vomiting, epigastric pain, hematemesis, diarrhea.

Central nervous system: headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.

Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias.

Respiratory: tachypnea.

Renal: albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis.

Others: rash, hyperglycemia and inappropriate ADH syndrome.

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AN UPDATE IN OBSTETRICS AND GYNECOLOGY FOR THE PRACTICING PHYSICIAN: April 4-5; Westin Hotel, Cincinnati; sponsor: Bethesda Hospital, Inc., Cincinnati; 10 credit hours of Category I; fee: $250; contact: Thomas O'Connor, CME, Bethesda Hospital, Inc., 619 Oak Street, Cincinnati 45206, phone: 513/569-6339.

MEDICAL PROGRESS FOR THE PRIMARY PHYSICIAN: April 16-17; Bunts Auditorium, Cleveland; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: $160; contact: Center of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106; phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

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INFANT DEVELOPMENT: IMPLICATIONS OF RESEARCH AND THEORY FOR TREATMENT: April 21; Harding Hospital, Worthington; sponsor: The Harding Hospital, Worthington; 6 credit hours; fee: $55; contact: Symposia Registrar, Harding Hospital, 445 East Granville Road, Worthington 43085, phone: 614/885-5381, ext. 326.

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WORKSHOP ON THE DIFFERENTIAL DIAGNOSIS OF BERYLLIUM DISEASE: May 7-8; The Cleveland Clinic Foundation; sponsor: The Cleveland Clinic Educational Foundation; 9 credit hours; fee: $175; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106; phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

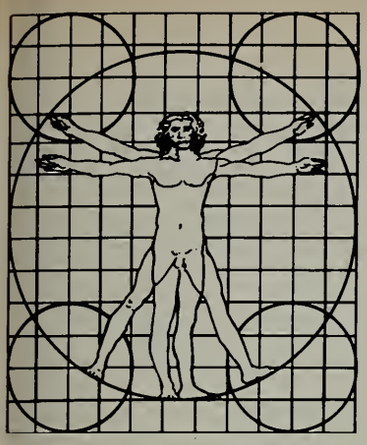
CURRENT TOPICS IN LABORATORY MEDICINE: May 7-9; Bunts Auditorium, Cleveland Clinic; sponsor: The Cleveland Clinic Educational Foundation; 16 credit hours; fee: $250; contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106; phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

REFRESHER SEMINAR IN PEDIATRICS: May 14-15; Bunts Auditorium, Cleveland Clinic; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: $170; contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106; phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

CORONARY ARTERY DISEASE: May 15; St. Elizabeth Hospital Medical Center, Youngstown; sponsor: St. Elizabeth Hospital Medical Center; 3 credit hours; no fee; contact: Rashid A. Abdu, M.D., St. Elizabeth Hospital Medical Center, 1044 Belmont Avenue, Youngstown 44501; phone: 216/747-7211.

HEADACHE UPDATE: May 28; Bunts Auditorium, Cleveland Clinic; sponsor: The Cleveland Clinic Educational Foundation; 6 credit hours; fee: $90; contact:

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CLINICAL & SCIENTIFIC

HYPERTENSION IN THE GERIATRIC PATIENT: RATIONALE FOR DRUG SELECTION

Kim Goldenberg, MD, FACP

Hypertension is a common and often difficult management problem in the elderly. It is especially problematic in relation to drug treatment in which multiple potential side effects are possible. The necessity for treating isolated systolic and/or mild diastolic hypertension, however, is unproven, but the limited data available suggests a benefit. Any approach to selection of anti-hypertensive treatment should integrate a knowledge of the drug's action and potential side effects with the pathophysiology of aging. An evaluation of the risks and benefits of drug treatment is presented along with a rationale for selecting different medications in the geriatric patient.

The prevalence of hypertension increases with age with about 50% having an elevation in the systolic, diastolic or both after 65 years of age; systolic hypertension is predominantly seen in the elderly. The physiologic changes of aging tend to alter the pharmacokinetics and augment the side effects of the drugs commonly used in therapy. Although no large prospective drug trial has been done in elderly patients with hypertension, the implications of available studies suggest a benefit. Using the stepped-care approach suggested by the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure[1] as a treatment framework, a discussion of each drug class is presented in relation to its relative benefits and risks.

Definitions and Pathophysiology

Epidemiologically, the elderly are defined as those ≥65 years old, and the frail elderly ≥75 years. This arbitrary designation, however, does not account for the large individual variation in the aging process. Two types of hypertensive subgroups can be identified: diastolic hypertension (BP ≥ 90mmHg), usually representing essential hypertension of many years duration with a pulse pressure <80mmHg; and systolic hypertension (BP≥160), usually representing systolic only or combined hypertension with a pulse pressure ≥80mmHg. The latter subgroup is usually associated with middle and large vessel wall rigidity as a consequence of arteriosclerosis, and, to a lesser extent, with plaque formation. Caution is, however, necessary in designating hypertension secondary to vessel wall rigidity. Some elderly people have hardened arterial walls that may be difficult to compress by the sphygmomanometer cuff resulting in a falsely high reading, "pseudo-hypertension."[2] This phenomenon can usually be identified by checking for a peripheral, i.e. radial, pulse after the compression of a more proximal artery, i.e. brachial, to just above the point of occlusion, i.e. systolic reading — Korotkoff I. Due to the arterial wall changes with aging, the difficulty in assessing the true cut-off designation for hypertension is augmented. Vessel changes may cause a decrease in arterial wall compliance and increased peripheral resistance leading to a diminution in cardiac output and plasma volume. Thus, the elderly may develop organ system dysfunction due to hypertension and the aging process itself. Selected aspects of the pathophysiology of aging which may relate to the elderly and their use of antihypertensive medication is shown in Table 1. These major pathophysiologic processes, in relation to the current spectrum of anti-hypertensive medications, puts the elderly at relatively greater risk for drug side effects. The risks and benefits of drug intervention are controversial due to the paucity of research data on the geriatric population.

Rationale for Treatment

No large prospective trials demonstrate that medical treatment of hypertension significantly benefits the elderly. Nevertheless, the implications of the limited studies available offer some guidelines. Indirect evidence of benefit has been seen in studies on the risks of hypertension. A causal relationship between low-

Kim Goldenberg, MD, FACP, director of the General Internal Medicine Division, Wright State University School of Medicine, Department of Medicine, Miami Valley Hospital, Dayton, Ohio.

Table 1.
Selected Aspects of Aging Pathophysiology

Organ System	*Aging Physiology*	*Potential Clinical Effect*
Gastrointestinal	Salivary, gastric and pancreatic secretions are decreased	Dry mouth, absorption is diminished
	Liver undergoes atrophy and enzymatic changes	Drug metabolism is impaired
	Intestinal motility is decreased and disorganized	Constipation, diarrhea
Cardiovascular	Myocardial hypertrophy and fibrosis occur	Cardiac arrythmias
	Arterial rigidity and peripheral resistance are increased	Systolic blood pressure elevation
	Baroreceptor sensitivity is diminished	Hypotension and syncope
Renal	Nephrons are diminished	Drug excretion is impaired
	Bladder tone is decreased	Urine incontinence
	Prostatic hypertrophy	Urine retention
Endocrine	Insulin sensitivity and glucose tolerance are decreased	Hyperglycemia
Musculoskeletal	Muscle mass is decreased and disorganized	Muscle strength reduction
Neurologic	Cerebral cortex and basal ganglia cells are decreased	Memory and movement reduced

ering blood pressure and lowering mortality cannot be assumed since hypertension may, in part, be an epi-phenomenon. A major risk and benefit controversy relates to whether lowering the systolic and diastolic blood pressures to reduce the potential risk of stroke and coronary artery disease also compromises cerebral and coronary blood flow; and, if so, at what pressure levels? Nonetheless, the significant cardiac and cerebrovascular mortality and morbidity in this age group presses the physician to draw provisional conclusions from the scant data available. For example, the Framingham study showed that hypertension (> 165/95 mmHg) was a major risk factor for congestive heart failure,[3] coronary artery disease[4] and stroke,[5] with the systolic and diastolic pressures being independent risk factors.[4] In the age range of 65-74 years, there was at least a threefold increase in the incidence of cardiovascular disease observed.[6] Similarly, in the Chicago Stroke Study[7-8] and Veteran's Administration Study,[9] morbidity and mortality increased with increasing levels of blood pressure and age. In the latter study, half the cardiac and cerebrovascular morbidity occurred in patients over age 60, although these patients account for only one-fifth of the hypertensive study group.

Direct evidence for a benefit from anti-hypertensive medication in the elderly is limited to small non-prospective trials. The implications of these studies, however, suggest a benefit. For example, in the Hypertension Detection and Follow-up Program,[10] 2,376 patients age 60-69 years were randomized into two roughly equal groups. After five years the stepped-care group had an average diastolic pressure of 81 mmHg and a 12.7% mortality compared to the referred-care group of 86 mmHg and a 15.2% mortality. Although the difference is only 2.5%, it represents 2.5 lives saved per 100 hypertensives and a net risk reduction of 16.4% in each patient. There are problems in extrapolating from this study including their limited number of patients over age 65 and their use of diastolic pressures for entry into the study. Mortality appeared to be reduced in the National Heart Foundation of Australia's Study,[11] involving 582 patients between 60 and 69 years, although the entry diastolic pressure was 95 mmHg. The Veteran's Administration Study Group's[9] data on 81 randomized high-risk male veterans, age 60-75 years, showed that after an average of three years, cerebrovascular accidents were 23% in the untreated group compared to 8% in the treated group. A decrease was also found in the incidence of congestive heart failure (21% in the untreated group compared to zero in the treated group). Coronary thrombosis, however, showed no difference between the two groups. Problems with extrapolating from this study includes the small number of patients studied, a high-risk male population, and the entry diastolic pressure of 90 to 114 mmHg. Since indirect and direct evidence for a need to treat hypertension in the elderly is inadequate, but available data suggest a benefit, I recommend treating patients when therapy produces minimum or no side effects.

Benefit and Risk of Treatment

Pharmacokinetically, only absorption is relatively unaffected in the elderly, whereas receptor sensitivity, renal clearance, and hepatic metabolism show relative decreases.[12] The physiology of aging by organ or system and the related clinical effects are shown in Table 1. These clinical effects of aging can be compared to the action and potential side effects of each class of antihypertensive drug that is recommended in the stepped-care approach (Table 2).

Table 2.
Anti-Hypertensive Drug Class and Stepped Care

Diuretics (step 1)
- thiazides and related sulfonamides
- loop diuretics (i.e. furosemide)
- potassium sparing agents (i.e. triamterene)

Beta-adrenergic blockers (step 1 or 2)
- beta selective (i.e. atenolol and metaprolol)
- beta non-selective (i.e. nadolol, oxprenolol, pindolol, propanolol, timolol)

Central alpha-adrenergic agonists (step 2)
- clonidine, guanabenz, methyldopa

Peripheral alpha-adrenergic blockers (step 4)
- reserpine, guanethidine

Alpha-1 adrenergic blocker (step 2)
- prazosin

Smooth muscle vasodilators (step 3)
- hydralazine, minoxidil

Angiotensin converting enzyme inhibitors (step 2, 3, 4)
- captopril

Calcium entry blockers (step 2, 3, 4)
- nifedipine, diltiazem, verapamil (all pending approval by FDA).

Diuretics

A thiazide diuretic (Step 1) is usually the least expensive antihypertensive medication and there is a well-defined spectrum of side effects based on years of experience with the drug. The European Work Study Group reported that thiazides were effective as a single agent in 85% of elderly patients,[13] and the Systolic Hypertension in the Elderly Program Feasibility Trials reported minimum side effects.[1] Potential disadvantages of thiazides include volume depletion, which in the elderly increases the potential of orthostasis and/or syncope. Diminished vascular volume may also decrease renal perfusion in the elderly in whom there may already exist an age-related decrease in renal function; albeit the blood urea nitrogen and serum creatinine may be normal. Carbohydrate intolerance is another area of physiologic deterioration which may be enhanced by a thiazide.[14] Hyperglycemia may result from a thiazide-induced hypokalemia and/or reduction in total body potassium leading to a decrease in insulin se-

cretion.[15] Other metabolic changes which may occur include decreases in sodium, magnesium, phosphate, and chloride with the latter resulting in a relative metabolic alkalosis.

The ability of elderly patients to respond to these changes is hampered by altered homeostatic mechanisms. An additional physiologic change of concern is a decrease in sexual function. Since aging can also produce this effect, whether the drug and aging process are synergistic is unknown. Other potential side effects in the elderly include hypercholesterolemia and hypertriglyceridemia, but these may be of less concern than in the young. Patients may also develop hyperuricemia (>10-12mg%) and may be appropriately treated or anti-hypertensive medication changed, although this issue is unresolved.

Beta-adrenergic blockers

Another recommended step 1 or 2 drug type is the beta adrenergic blocker. Their advantage in the elderly may include a benefit to the cardiac patient with coronary artery disease. The disadvantages include diminished receptor sensitivity and hepatic clearance resulting in higher blood levels of the drug for a given dose which may in part explain the increased incidence of side effects in the geriatric patient.[16,17,18] Elderly patients with a physiologic and/or pathologic compromise in hepatic and renal function will tend to have more side effects with those beta blockers that are metabolized or eliminated by hepatic and renal mechanisms. For example, propanolol and metaprolol are metabolized by the liver; nadolol and atenolol are excreted by the kidney; and timolol and pindolol are metabolized by the liver and excreted by the kidney.[19] The half life and side effects of these drugs are, in part, predictable if hepatic or renal insufficiency are present beyond that seen due to aging. Side effects can be predicted from the known action of beta blockade; for example, slowing of the heart rate and atrio-ventricular conduction may be enhanced by underlying myocardial hypertrophy and fibrosis. The decrease in cardiac output may lead to syncope if baroreceptor sensitivity is significantly diminished. Orthostatic hypotension, however, is usually not a significant problem. Another area of concern is the glucose intolerance and potential augmentation by the non-selective beta blockers of insulin induced hypoglycemia where masking of the normal adrenergic manifestations can occur. This is a particular concern in the elderly patient on insulin or oral hypoglycemic therapy for diabetes. Chronic obstructive pulmonary disease is relatively common in the elderly; and in those with a history of bronchospasm, non-selective beta blockers are contraindicated. The use of beta blockers with a minimal tendency for bronchospasm, i.e. beta-1 selective agents such as atenolol and metaprolol, is problematic in high-risk patients, since even at low doses selectivity is only relative. Pindolol, which has some intrinsic sympathomimetic activity, may have a relative advantage in bradycardic patients.

Non-selective beta blockers such as nadolol, timolol and propanolol have a potential advantage in patients with diminished baroreceptor sensitivity and a tendency toward orthostatic hypotension, since they tend to decrease the supine and increase the standing blood pressure due to their augmentation of arteriolar constriction and peripheral resistance. This effect, however, is uncommon in elderly patients with decreased norepinephrine receptor sensitivity which diminishes with age.[20] Finally, the potential for central nervous system depression in the geriatric patient with impaired memory or movement might be minimized by using a beta blocker that does not cross the blood-brain barrier, i.e. atenolol or nadolol.

Central alpha-adrenergic agonists

Another recommended step 2 drug class is the central alpha-adrenoreceptor brain stem stimulants, which inhibit sympathetic outflow to the periphery. These drugs, unlike the beta blockers, require caution in patients with orthostatic hypotension. Although clonidine and guanabenz are relatively safe, methyldopa is best used in low doses due to its concomitant peripheral competition for norepinephrine receptor sites. In general, the side effects with methyldopa are mild and the drug is well tolerated in the elderly.[14] The advantages of these drugs in the elderly relate to the absence of a significant cardiac or renal effect, thereby making them useful in patients with compromised function of these organ systems. Methyldopa, on the other hand, is contraindicated in patients with active liver disease due to its potential for a viral-like hepatitis, intrahepatic cholestasis, and granulomatous hepatitis, albeit rare. Both methyldopa and clonidine, by virtue of acting on the central nervous system, may produce sedation; this is more common in the latter. Like the beta blockers, these drugs should be used cautiously, if at all, in patients with impaired memory or motion. Given the elderly's proclivity for these gastrointestinal effects of dry mouth and constipation, these drugs may enhance the physiologic changes of aging.

All drugs in this class, as well as in other classes, have the potential for rebound and/or overshoot hypertension if suddenly stopped. Clonidine has, perhaps, the greatest tendency toward this "discontinuation" syndrome,[21] which is a particular concern in the elderly who may be on relatively high doses to suppress marked elevations in systolic blood pressure. If these patients are also taking a beta blocker, the sudden removal of a central alpha-adrenoreceptor agonist leaves alpha receptors and vasoconstriction unopposed by blocked beta receptors and vasodilatation. The potential result can be a net, marked rebound in hypertension. Guanabenz, like clonidine, may produce rebound hypertension, but unlike clonidine does not cause significant sodium and fluid retention. Thus Guanabenz may be particularly useful in the elderly with a history of congestive heart failure.

Peripheral alpha-adrenergic blockers

Another recommended step 2 drug is the peripheral alpha-adrenoreceptor blocker, reserpine, which has been very successful in the Veteran's Administration studies at low doses. In the elderly, however, lethargy and mental depression are serious potential side effects. Another peripheral blocker, guanethidine, is usually reserved as a Step 4 drug because of severe sympathetic blockade and tendency toward orthostatic hypotension.

Alpha-1 adrenergic blockers

These adrenoreceptor blockers act at a post-junctional site. Prazosin produces dilatation of arterioles (lowered resistance) and veins (increased capacitance). Since blood pressure is lowered in all positions, the elderly with diminished baroreceptor sensitivity are particularly prone to orthostatic hypotension and syncope. The combined effect of lowering both pre- and post-cardiac load, however, is advantageous in patients with congestive heart failure. As with the centrally acting agents, renal blood flow is not impaired and this class is safe to use in the presence of renal insufficiency.[22]

Smooth muscle vasodilators

Drugs such as hydralazine (step 2 or 3) and minoxidil (step 3) act directly to relax vascular smooth muscle primarily in the arterioles. Minoxidil is the most potent. They reduce peripheral resistance, diastolic blood pressure, stroke volume, and cardiac output. In response to these hemodynamic changes, the baroreceptor system mediates a sympathetic discharge and reflex tachycardia may result. Hydralazine, however, does not usually produce the same side effect of tachycardia in the elderly as in the younger patient due to decreased baroreceptor sensitivity. Hydralazine maintains or increases renal and cerebrovascular blood flow making it especially useful in elderly patients with renal and/or cerebrovascular insufficiency. Minoxidil is often useful in renal failure patients, but its potency and tendency to cause a reflex tachycardia and volume retention usually requires the concomitant use of a diuretic and a beta blocker. Caution is warranted in the elderly; therefore, this drug should probably be considered a step 4 agent.

Angiotensin-converting enzyme inhibitors (ACEI)

A potential step 2, 3 or 4 agent is captopril, an ACEI, which has multiple sites and modes of action including the vasodilator

prostaglandins[23] and decreases in systemic vascular resistance. Other effects of vasodilators, however, do not occur such as decreased cardiac output and reflex tachycardia since the baroreceptors are relatively unaffected. Volume expansion does not occur which may be due to an inhibition of aldosterone secretion. Renal blood flow is usually maintained or increased making this drug useful in patients with renal insufficiency. Caution, however, in patients with renal failure is appropriate since membranous glomerulonephritis is a potential, albeit rare, side effect, and bilateral renal artery stenosis, if present, may worsen. In the elderly with a decreased glomerular filtration rate and creatinine clearance, regular checks for proteinuria are warranted. When starting this agent, a baseline CBC and differential followed by regular checks for agranulocytosis is also prudent. ACEIs are an advantage in elderly patients with congestive heart failure due to their activity as vasodilators and cardiac after-load reducers.

Calcium entry blockers

Another potential step 2, 3, or 4 agent, not yet approved by the Federal Drug Administration, is a calcium channel blocker such as nifedipine, verapamil, and diltiazem. These drugs are potent smooth muscle vasodilators but, unlike the other vasodilators, have less reflex tachycardia. Nifedipine has the greatest effect on peripheral vasodilation and the least on negative chronotropism. In the elderly with bradycardia, coronary artery disease with or without angina, supraventricular arrythmias, and/or mild left ventricular dysfunction, these agents may be beneficial.[24]

Table 3.
Treatment of Selected Chronic Problems Associated with Hypertension in the Elderly.

	Potential Benefit	*Potential Risk*
Cerebrovascular Disease	S	C, P
Congestive Heart Failure	D, A1	B, Ca
Coronary Artery Disease	B, Ca	—
Renal Failure	D, A, S	—
Diabetes Mellitus	—	B, D
Pulmonary Obstructive Disease	—	B
Orthostatic Hypotension	B	P, A1
Sexual Dysfunction	—	B, C, D, P

Special Disease Problems in the Elderly

The complications of hypertension are more common in the elderly since it is usually of longer duration with a greater frequency of end organ damage, and the elderly have an increased likelihood of certain diseases (See table 3). The cerebrovascular changes of aging, in particular a stroke history, suggest extra care in lowering systolic blood pressure since it is important in the maintenance of cerebral blood flow. Low doses of a thiazide diuretic alone are often beneficial. In high doses, volume depletion and hypotension may predispose to a stroke, i.e. the problem to be prevented. Similarly peripheral and alpha-1 blockers such as guanethidine and prazosin should be used cautiously, if at all, because of their tendency to produce orthostatic hypotension. In contrast, the central alpha-adrenergic blockers such as clonidine may result in rebound hypertension if stopped abruptly, a phenomenon to be avoided in the elderly with cerebrovascular disease.

In patients with cardiac disease, several antihypertensive drugs have more than one effect. For example, in congestive heart failure (CHF), a diuretic is useful in all stages of disease, and angiotensin converting enzyme inhibitors and alpha-1 adrenergic blockers may be useful in controlling severe disease. Drugs which may worsen or precipitate CHF include the beta blockers which have a negative ionotropic effect due to their beta-1 receptor blocking effect. Although specific beta blockers are presumably beta selective in low doses, this selectivity is only relative and of no value in CHF. Calcium entry blockers also produce a negative ionotropic effect. Verapamil is most potent in this regard and nifedipine and diltiazam the least. Nifedipine's negative ionotropic effect tends to be offset by its vasodilating effect in congestive heart failure patients since it reduces both pre- and after-load.[25] In contrast, patients with coronary artery disease may benefit from the beta blockers as well as the calcium channel blockers. Beta blockers may also be useful in hypertensive patients with non-drug induced orthostatic hypotension, although only a minority respond.

In patients with obstructive pulmonary disease and bronchospasm and diabetes, even the relatively selective beta blockers are generally a greater risk than benefit. Patients with only a "history" of bronchospastic pulmonary disease are also at increased risk. In diabetic patients, beta blockers may mask the adrenergic warning signs of hypoglycemia. With all patients, particularly in diabetics, anti-hypertensive agents may cause or exacerbate impotence. Switching drug type rather than within drug type may be helpful. Finally, patients with renal insufficiency well beyond the physiologic nephron loss of aging (i.e. creatinine >2.5) will usually require a loop diuretic. Diuretics can usually be titrated so as not to accentuate renal failure. Each drug class has some effect on renal blood flow which was recently reviewed.[26]

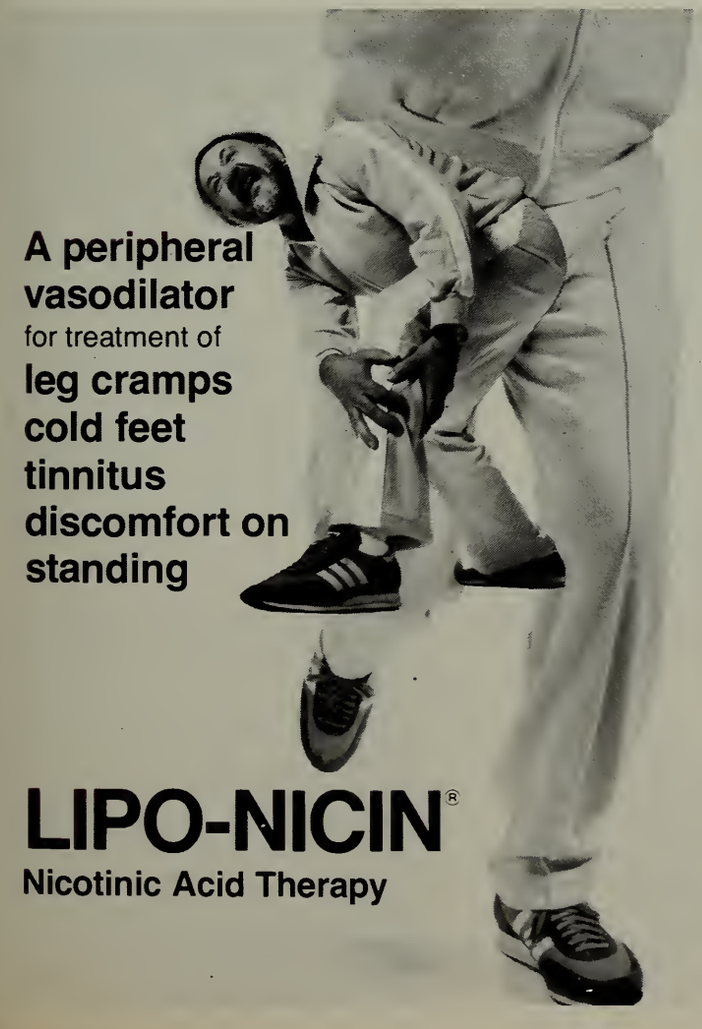
In the elderly person with hypertension and special disease problems, initial salt and/or calorie restriction should be tempered by a knowledge of the patient's present diet and ability to taste and digest food which may already be compromised. When drugs are selected, diuretics are usually the most inexpensive and effective even in the elderly with other diseases. In the Multiple Risk Factor Intervention Trial (MRFIT), however, diuretic use in the special intervention group as compared to the usual care group had a higher mortality in those patients with an abnormal baseline EKG.[27] Although these patients were not elderly and the implications of this study are not yet known, it seems prudent to monitor diuretic side effects closely. In the Systolic Hypertension in the Elderly Program (SHEP) feasibility trials, diuretics were found to be safe and effective in controlling systolic hypertension.[1] In summary, the limited data suggest benefit in treating systolic and/or mild diastolic hypertension. Until more evidence is obtained, however, a conservative lowering of blood pressure seems warranted, tempered by a current knowledge of the physiology of aging and the effects of the drugs to be used, "primum non nocere."

Key: A = angiotensin converting enzyme inhibitor, B = beta-adrenergic blocker, C = central alpha-adrenergic blocker, Ca = calcium entry blocker, D = diuretic, P = peripheral alpha-adrenergic blocker, S = smooth muscle vasodilator, Al = alpha-1 adrenergic blocker.

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for treatment of
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Effective and versatile *b.i.d.* therapy

Before prescribing, please consult complete product information, a summary of which follows:

CONTRAINDICATIONS: Hypersensitivity to trimethoprim or sulfonamides; documented megaloblastic anemia due to folate deficiency; pregnancy at term and during the nursing period; infants less than two months of age.

WARNINGS: FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently.

BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS:

General: Give with caution to patients with impaired renal or hepatic function, possible folate deficiency and severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur, frequently dose-related.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently; if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffé alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenesis: Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. *Mutagenesis:* Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. *Impairment of Fertility:* No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folic acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS and CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).** *Hematologic:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, methemoglobinemia, eosinophilia. *Allergic Reactions:* Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. Periarteritis nodosa and systemic lupus erythematosus have been reported. *Gastrointestinal:* Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. *Genitourinary:* Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. *Neurologic:* Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. *Psychiatric:* Hallucinations, depression, apathy, nervousness. *Endocrine:* Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. *Musculoskeletal:* Arthralgia, myalgia. *Miscellaneous:* Weakness, fatigue, insomnia.

DOSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age.

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ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS: Usual adult dosage is one DS tablet, two tablets or four teasp. (20 ml) *b.i.d.* for 14 days.

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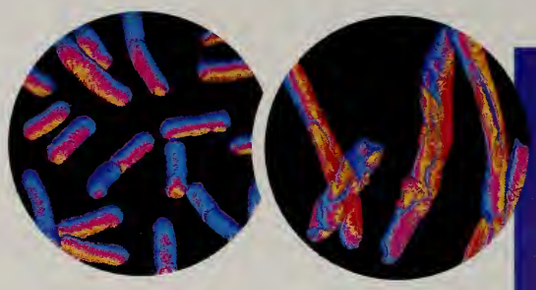
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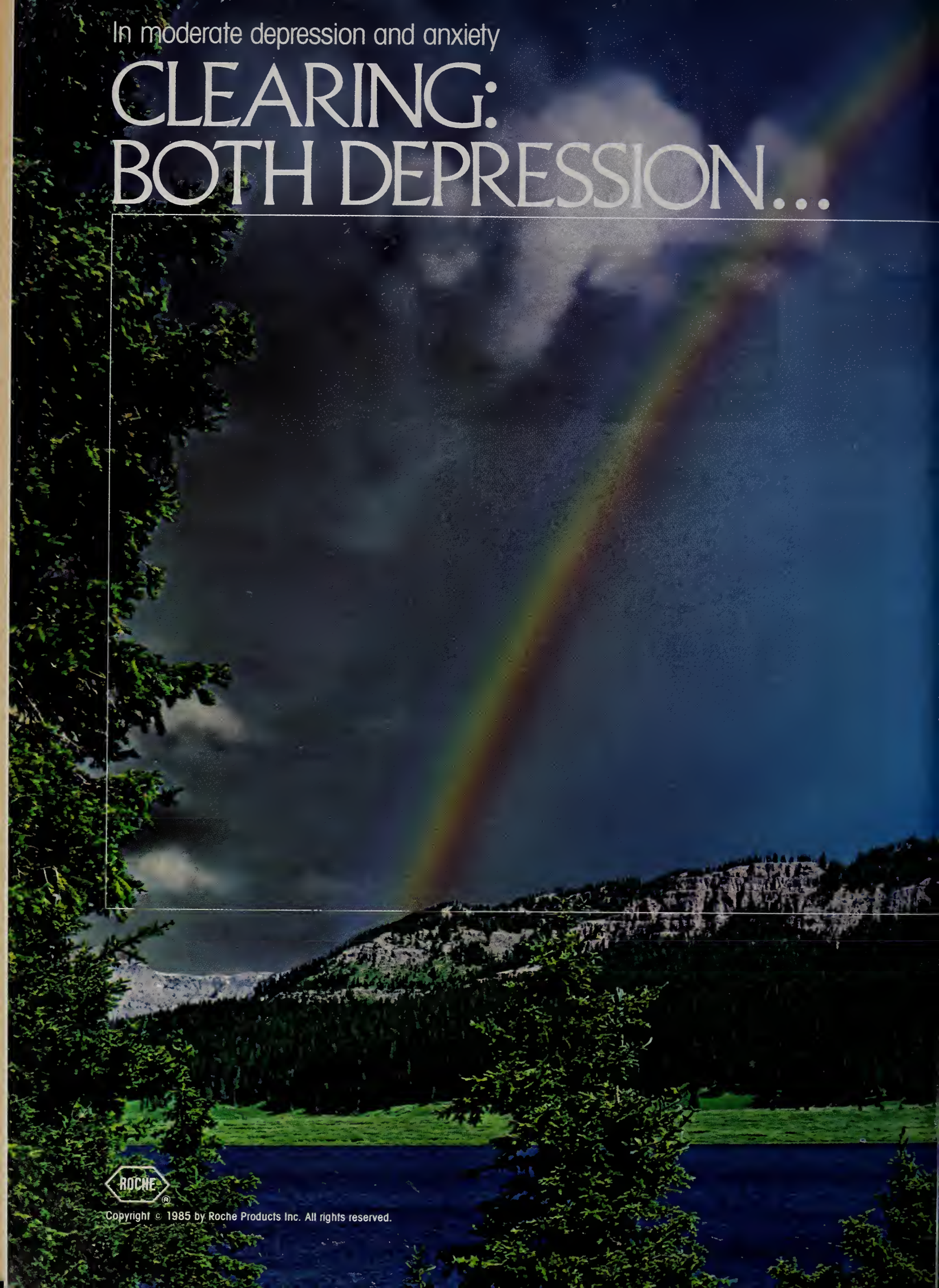
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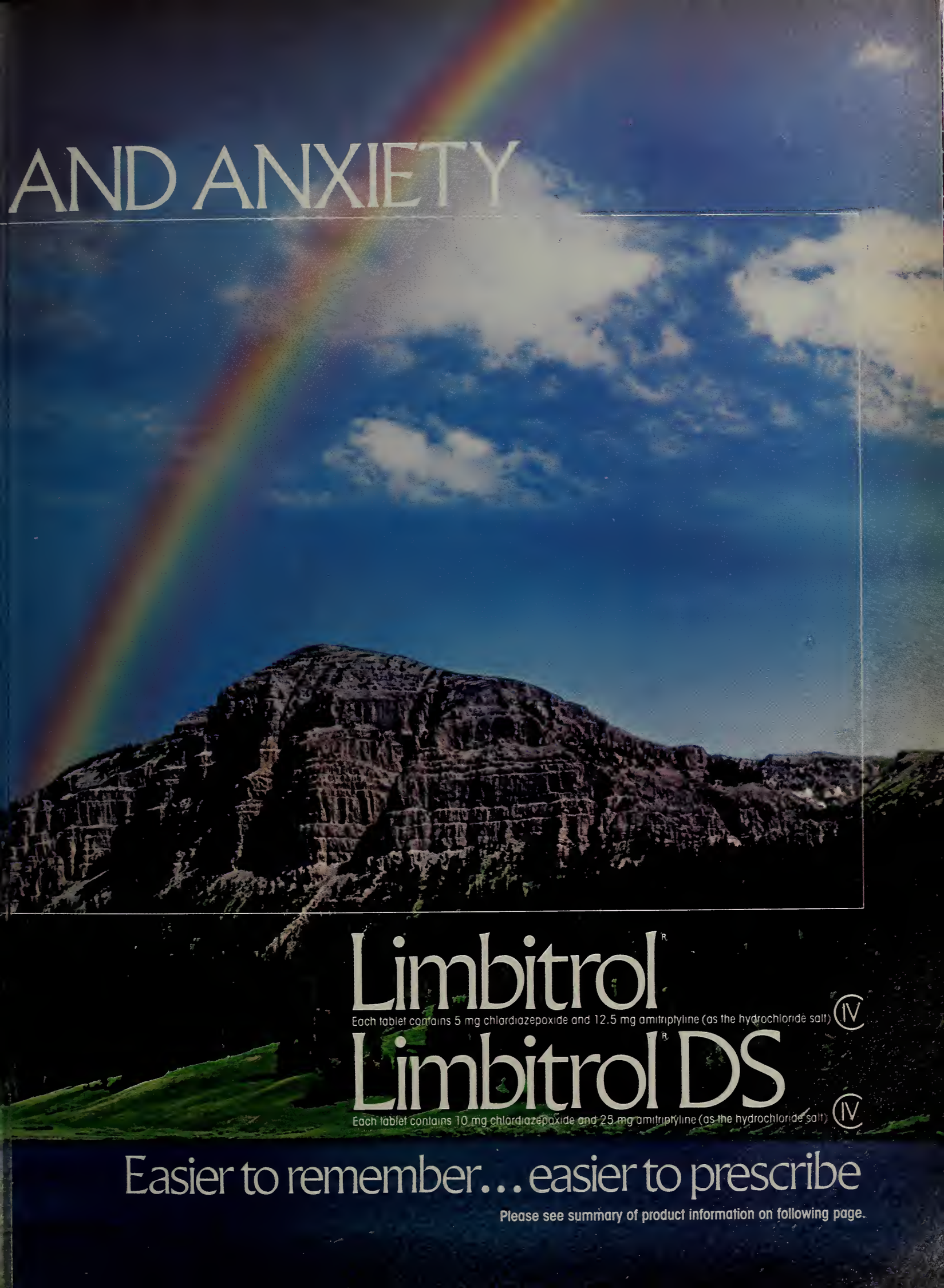
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Before prescribing, please consult complete product information, a summary of which follows:
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Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.
Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
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Herman I. Abromowitz, MD

The OSMA in Action

By Herman Abromowitz, MD

"No man is an island, entire of itself; every man is a piece of the continent, a part of the main . . ." — John Donne

In the practice of medicine, there is a tremendous temptation for a physician to become "an island, entire of itself." The demands of the profession, the hectic pace, the too few moments with family and friends, all make it appealing to avoid outside commitments and responsibilities which take from us one of our most precious commodities: time.

I have written, in a previous column, about how important involvement is within an individual physician's personal community. But, in my opinion, it is also important — especially in the environment of medicine today — that we all make the effort to be involved in organized medicine. Physicians need contact with other physicians to share and explore individual and collective thoughts and ideas so that together we can and will be a significant factor in the continuum of the delivery of quality medical care.

Meeting and becoming acquainted with physicians on a local, state and national level is a must. It gives us the greater perspective of the "big picture." It is readily apparent that the issues facing medicine today are not just local, parochial issues. All physicians are being confronted with the same types of problems and concerns. Therefore, it is obviously important that involvement on all levels — local, state and national — is so vital to each of us as physicians and to each patient we serve to ensure that quality medical care will not and must not be sacrificed.

One individual physician can make a difference and time and time again we have seen where a single resolution introduced by one Ohio physician has risen through the ranks on all levels to win the support and endorsement of physicians throughout the United States.

This is indeed the American Way. Where one physician can influence American Health Care Policy. This is democracy in its finest form and this is what involvement can mean to each of us.

You, indeed, can make a difference with your presence at the 1986 OSMA Annual Meeting. At this meeting resolutions submitted by concerned and caring physicians all over Ohio will be studied and debated. Out of this meeting comes the policy which sets the future course of our Association. The OSMA needs your input and your ideas. The Annual Meeting is now upon us. Let us all attend. I look forward to personally greeting each of you.

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Doctor, Are You Ready to Blaze New Trails?

As medicine continues to blaze new trails — not only in the treatment of disease, but also in such unexplored areas as alternative delivery systems and competition and marketing — the question "where do we go from here?" becomes a vital one. The steps which you, as physicians, take *now* will mark for sure the course of medicine for a whole *new* generation of health-care professionals.

That is why the discussion, the debate, and the resolves which take place each year at Annual Meeting are becoming more important. At Annual Meeting, you and your colleagues have the opportunity to collectively explore — even direct — the paths which medicine will take in the years ahead. It is not your only opportunity, of course. Your participation on OSMA committees and task forces, your help on special projects, and your willingness to get involved during legislative alerts all provide you with opportunities to direct the future course of your profession. But Annual Meeting provides you with the greatest scope of opinions on what that future course should be and what directions should be taken to reach it.

This year's meeting will be May 2-7 in Dayton, Ohio. A special section in this issue is devoted to preliminary information about this meeting — the who, what, where and when of it. Make plans, now, to attend. Medicine needs the collective thinking of *all* of its participants if the question "where do we go from here?" is to be answered in the same intelligent yet compassionate way it has been in the past.

Medicine needs the collective thinking of all of its participants if the question "Where do we go from here?" is to be answered.

In unrelated matters this month, you'll find our "Ohio Medi-scene" section has an interesting assortment of stories this month — everything from an AIDS update to a possible new treatment for osteoporosis. OSMA Second District Councilor William J. Marshall, MD, takes a look at the generic drug issue — should you prescribe them or shouldn't you?

And with malpractice feelings still running high (we'll be focusing on this subject again next month), officials at PICO have contributed a timely article, "1985 Overview," which provides a look at the situation from *their* perspective. Also in this issue: Assistant Communications Director Doug Evans reports on an exciting new national program for indigent care which Ohio ophthalmologists will be participating in this spring, and OSMA Membership Chairman Thomas Morgan, MD, has written what may become part of a new *Journal* series on membership.

Which brings us back to a telling point. No one ever said that the health-care profession offered an easy path to follow, and, admittedly, there now seems to be more brambles and thickets in the path than ever before. But medicine has never been without its trail-blazers, either. Next month, they will all be in Dayton. Will you? — *Karen S. Edwards*

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(b). A copy of the manuscript should be retained by the Author.
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(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

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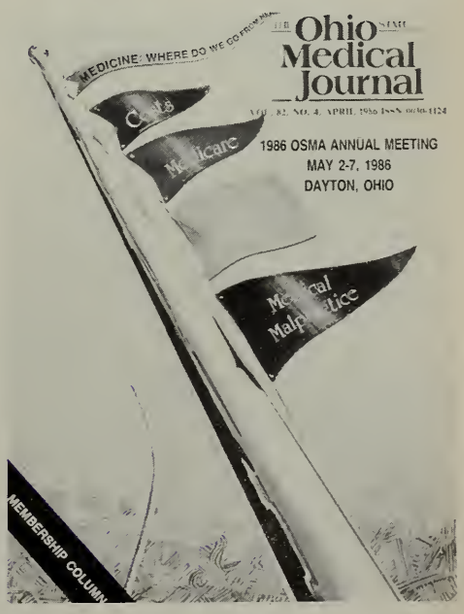
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Letters to the Editor

The quality of care

To the Editor:

In response to "Where's the Patient?" in the Second Opinion by Kenneth L. Wehr, MD (*OSM Journal,* February, 1986), I would like to express my opinions. The key words quality and health have been defined. In the *New York Times* magazine of November 2, 1980, Barbara Tuchman defined quality as, "investment of the best skill and effort possible to produce the finest and most admirable result possible." Quality has two identifiable divisions: subjective quality and objective quality. Webster's Dictionary defines health as "the condition of being sound in body, mind or soul." United Health Resource, Inc. identifies six divisions of health:

- **physical health** — the condition of the individual physical body;
- **emotional health** — the condition of feeling, such as a sense of belonging, feelings of well-being, absence of debilitating repressed emotions, etc.;
- **mental health** — the condition of the thought patterns, such as attitudes, ethics, creativity, etc.;
- **organizational health** — quality of work life, organizational growth, organizational profitability, etc.;
- **superordinate health** — family, social, purposefulness within the context of society, etc.; and
- **spiritual health** — the condition of significant transpersonal values, such as higher ethics, aspirations, etc.

In the last sixteen years, I have had the privilege to audit myself and hundreds of physicians. My findings suggest that within a group of physicians, there is a normal distribution with a tight or slight variation in the nature of care they deliver. If quality is being "close" to your peers, then 95 percent of the physicians were practicing a high quality of medicine. The argument then settles around distinguishing whether or not the practice characteristics of 5 percent of the physicians are below acceptable standards or are enhancing the quality of health care.

Dr. Wehr, "the quality of health care is still most important to the physician." We will not yield to the "numerous motivations to play the 'business game!' "

Respectfully yours,
Darren N. Huggins, MD
Ashland, Ohio

The house call...alive and well

To the Editor:

In response to Ohio Medi-scene "The Return of the House Call" (*OSM Journal* January, 1986) I have the following observation:

In Franklin County the house call never left. Almost all of our 200 family physicians have made and continue to make regular, as well as episodic, house calls. Most pediatricians and general internists in private practice have made, and continue to make, house calls, as necessary, on their patients. In addition, many local surgeons, orthopedic surgeons, and other specialists make home visits from time to time under special circumstances.

The implication that physicians have abandoned their patients who become disabled or homebound is distasteful to all responsible members of the medical community.

Sincerely,
William T. Paul, MD
Columbus

Beware the water

To the Editor:

The Chemistry Department of Bluffton College has informed me that a glass of water in Bluffton has about two-thirds as much calcium as there is in a glass of milk. After I checked with the Ohio Northern School of Pharmacy in Ada, they agreed that this finding has clinical significance. Some of the implications are as follows:

— Bluffton patients should not take tetracyclines with a glass of Bluffton water (or reconstituted juice).

— Patients prone to Ca++ kidney stones should *not* drink large amounts of Bluffton water. Bottled water should be substituted.

— Patients at risk for osteoporosis would likely benefit from drinking more Bluffton water.

Bluffton water is extremely "hard." Nearly all residents have water softeners, but drinking softened water is a well-documented health hazard. Most people have a separate faucet for drinking water that bypasses the softener.

I would suggest that physicians in other communities with hard water be aware of the mineral content of their water because of the clinical implications of our frequent "benign" advice of "drink lots of water."

Sincerely,
L. Terry Chappell, MD
Bluffton, OH



Grandma's Back

And is she ever glad to be back. Back to her kitchen. Back to her everyday routine. Back on her feet again.

After a stroke paralyzed her left side, Esther thought she would never get back to doing the things she loved. That was before she learned about Harmarville Rehabilitation Center from an ad in the local paper.

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As for her family, they couldn't be happier to have back the grandma they know and love.

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Gorbachev's Brain

By Robert J. White, MD, PhD

Over the years, our various intelligence agencies have had considerable difficulty in obtaining meaningful and factual information about the health status and medical problems of the Soviet leaders. For example, it was heavily rumored and, indeed, known that Mr. Brezhnev was seriously ill, suffering from cardiovascular disease; yet the exact nature and extent of his illnesses were not really appreciated until after his death with the publication of his official autopsy report (signed, incidentally, by Dr. Y. A. Chazov, the co-winner of this year's Nobel Peace Prize).

Our lack of knowledge regarding Yuri Andropov's state of health was even more alarming. In his case, even though it was strongly suspected by a few highly privileged medical visitors to the Soviet Union that he was suffering from end-stage renal disease, and that expensive kidney dialysis equipment had been purchased by the Soviet Union from West Germany for his use, our espionage agencies were simply not convinced that he was seriously ill or suffering from a terminal disease process until his death was officially reported.

While it is true that the chronic medical infirmities of Konstantin U. Chernenko, notably emphysema and heart disease, had been known for years, the extent and finality of his illness, again, were simply not appreciated by such organizations as the CIA or other Western intelligence agencies until his official autopsy report (again released bearing Dr. Chazov's signature, as was true also of Andropov's) was available.

In sum and substance, then, we in the West have had an extremely poor "track record" in gathering exact medical information as it relates to the true health status of the Russian leaders. Now, however, the situation may be quite different, since the New Russian Premier, Mikhail S. Gorbachev, is only 54 years of age and, by all outward appearances, enjoys excellent health. But, how well is he? And does he have any neurological or psychological problems that could influence his decision making and thereby adversely affect relationships between our countries?

During a recent interview with *Time* magazine editors, it was reported that: "He (Gorbachev) dominates a meeting with three extraordinary tools: eyes, hands, and voice." Yet, fascinatingly, only cursory mention was made of the most startling aspect of his appearance, that of a very large, reddish-blue birthmark on the right side of his head and extending on to the right face. Even the only available English biography on Mr. Gorbachev, by T.B. Butson, does not even mention this interesting physical defect. While the Soviet Union is busily airbrushing the cosmetic deformity out of all governmental photographs of Mr. Gorbachev, there has been surprisingly little discussion of this abnormality in the Western press.

While this may represent nothing more than the classical "port wine stain" birthmark limited, in this case, to the scalp and face and composed of numerous and very fine blood vessels, it may, on the other hand, be associated with other more serious malformations involving the tissues and blood vessels of the brain itself.

One such malformation, known as the Sturge-Weber Syndrome, presents with a similar "port wine" colored facial nevus, as well as a dramatic atrophy and calcification of the cerebral cortex underlying the blood vessel abnormality in the scalp. Persons suffering from this birth defect

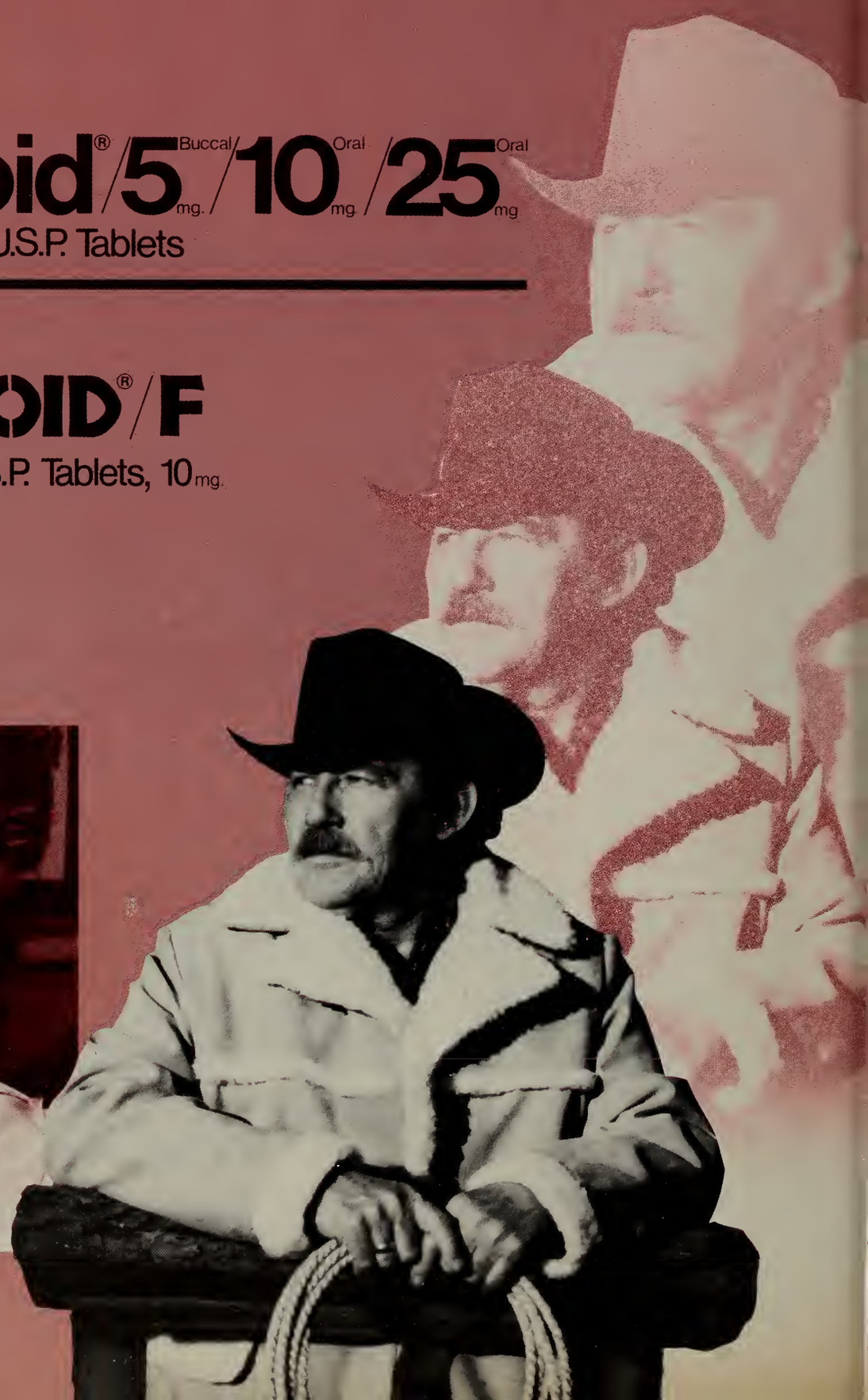
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Russian premier, Mikhail S. Gorbachev, is only 54 years of age and, by all outward appearances, enjoys excellent health. But how well is he?

Gorbachev's brain ... *continued*

often present with epilepsy and mental retardation.

Another vascular abnormality, which is reminiscent of what is seen on the head and face of Mr. Gorbachev, is a birth abnormality referred to as "sinus pericranii." These are collections of very thin-walled veins, which may connect directly through openings in the skull with the brain's own circulation. If the Soviet Prime Minister were to have this condition, even a minor bruise or laceration of the scalp could cause serious bleeding and, if not properly controlled, could lead to shock or air embolism of the brain.

Even after Mr. Gorbachev's extraordinary meetings with Mr. Reagan, when he was observed "close up," it is concerning that our intelligence/military agencies are not knowledgeable of whether the process that appears on Mr. Gorbachev's scalp is a benign or a dangerous lesion linked to his cerebral circulation. As a consequence, Mr. Gorbachev's brain and its appropriate functioning could be a subject of legitimate concern to the entire world. **OSMA**

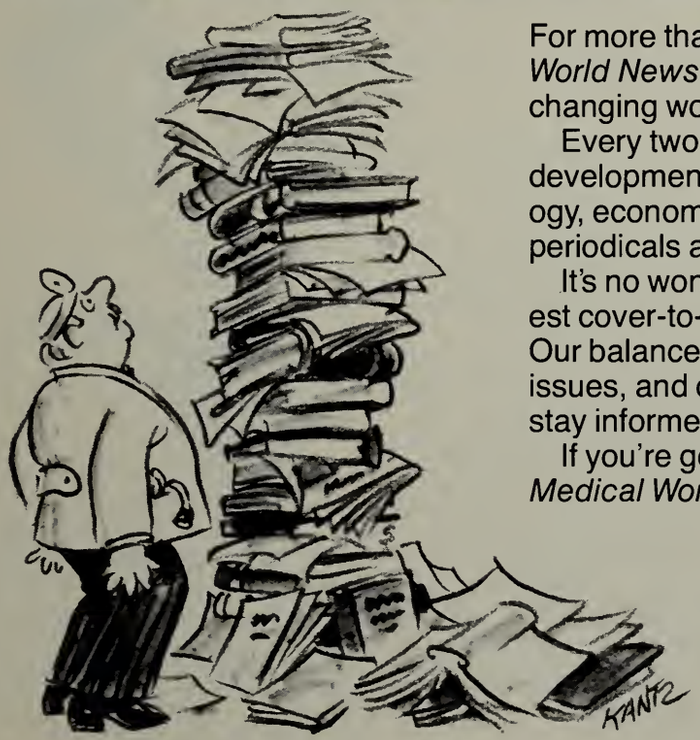
Robert J. White, MD, PhD, is a neurosurgeon practicing in Cleveland, Ohio.

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News Digest

Edited by Deborah Athy



Coffee and heart disease

Those at-risk for heart disease may want to pay heed to a new study which found that persons who drink five or more cups of coffee a day have a three times greater risk of developing heart problems than a person who drinks no coffee at all.

The study, conducted at John Hopkins Medical School, was an attempt to test three different theories: one, that coffee drinking in early adulthood is related to heart disease later in life; a second, that coffee consumption over a 25-year period had a cumulative effect; and, third, that a possible link between heart disease and coffee, consumed in the years just prior to the occurrence of the disease, may exist.

The main finding of the study, which reviewed the cases of 1,130 male medical students who graduated between 1948 and 1964, was that, compared to a person who drinks no coffee, the person who drinks five or more cups of coffee per day has a 2.8 times greater risk of having heart problems. Even when other risk factors were taken into account — smoking, high blood pressure, cholesterol and age — the study found that there is still a 2.5 times increased risk.

New test may detect osteoporosis sooner

A new diagnostic technique for osteoporosis may become as routine as mammographies, says Gordon DePuey, MD, a nuclear medicine specialist at Atlanta's Emory University.

Dr. DePuey is the creator of the dual-photon absorptiometry machine which emits rays that penetrate the body and measure bone density, providing early glimpses of any bone degenerations.

Earlier bone-scanning techniques measured bone density only in the wrist and arm, which tend to degenerate later than other bones. Dr. DePuey's machine, however, can measure bone density in the spinal column and deep-seated areas of the body where bone degeneration usually takes place first. The image is generated by computer and projected on a video screen.

Dr. DePuey foresees using the device to screen people at age 65, and every few years thereafter.

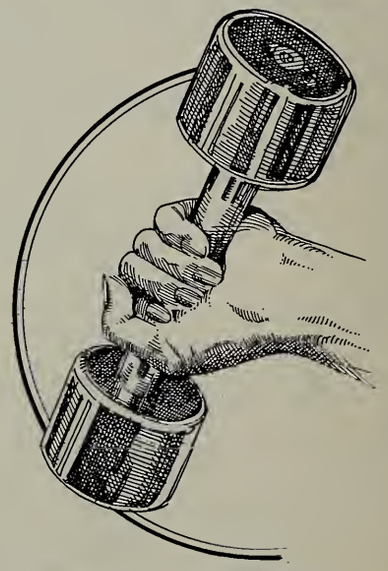
"If we can detect osteoporosis in its very early stages, we can start treatment to prevent it, before it ever starts causing problems," Dr. DePuey says.

Diabetes and exercise

People with diabetes should exercise on a regular basis to maintain improved insulin sensitivity, according to a recent study reported in *Diabetes,* a publication of the American Diabetes Association.

Physicians have known for some time that exercise appears to enhance the action of insulin on peripheral tissues; consequently, diabetic people who exercise require less insulin to achieve normal blood sugar levels.

But a new study, conducted at McGill and McMaster Universities in Canada, examined just how long the beneficial effect of exercise is maintained.



The results showed that "the exercise-induced improvement in insulin sensitivity is quite rapidly reversed following cessation of regular training, in contrast to the longer term benefits of exercise on other organ systems."

a compilation of the latest developments, reports and products of interest to physicians.

Physicians and the no-smoking campaign

Surgeon General Dr. C. Everett Koop envisions a society where nobody lights up. Not in a restaurant with a cup of coffee. Not in a bar. Not even at home. And he is asking physicians to make this vision a reality by the year 2000.

"Since I left Washington yesterday about this time, 1,000 people in this country have stopped smoking. They've stopped smoking permanently, and their funerals will be within the next three days. That's a terrible way to go about stopping smoking," Dr. Koop says in a recent article in the Cincinnati *Enquirer.*

"Cigarette smoking is still the most preventable cause of premature death of citizens in this land," he continues.

For this reason, Dr. Koop has launched a major offensive against the habit — which claims about 340,000 U.S. lives annually — and is calling on physicians to take the message beyond their offices by speaking at churches, community meetings and in schools.

Dr. Koop says it's essential that physicians join in the struggle toward a smoke-free society, since survey results show that a physician's no-smoking order to his patients has proven to be the most effective way to get a smoker to quit.



Anti-viral drug helpful in taming RSV

The Food and Drug Administration recently approved an anti-viral drug to combat respiratory syncytial virus (RSV), the most common cause of children's respiratory diseases.

The approval of the drug, Ribavirin, comes just as RSV activity is at its peak, according to Martin Myers, MD, director of the infectious diseases division at Children's Hospital Medical Center in Cincinnati.

In a recent article in the *Cincinnati Enquirer,* Myers cautions that the drug is not a "cure-all"; but, since 80 cases have already been reported at the center, the approval of the drug is an important first step in dealing with RSV diseases.

By the age of two, almost all children have been infected with RSV. Like cold and flu viruses, RSV spreads through secretions of an infected person and invades passages of the lungs, causing cold-like symptoms.

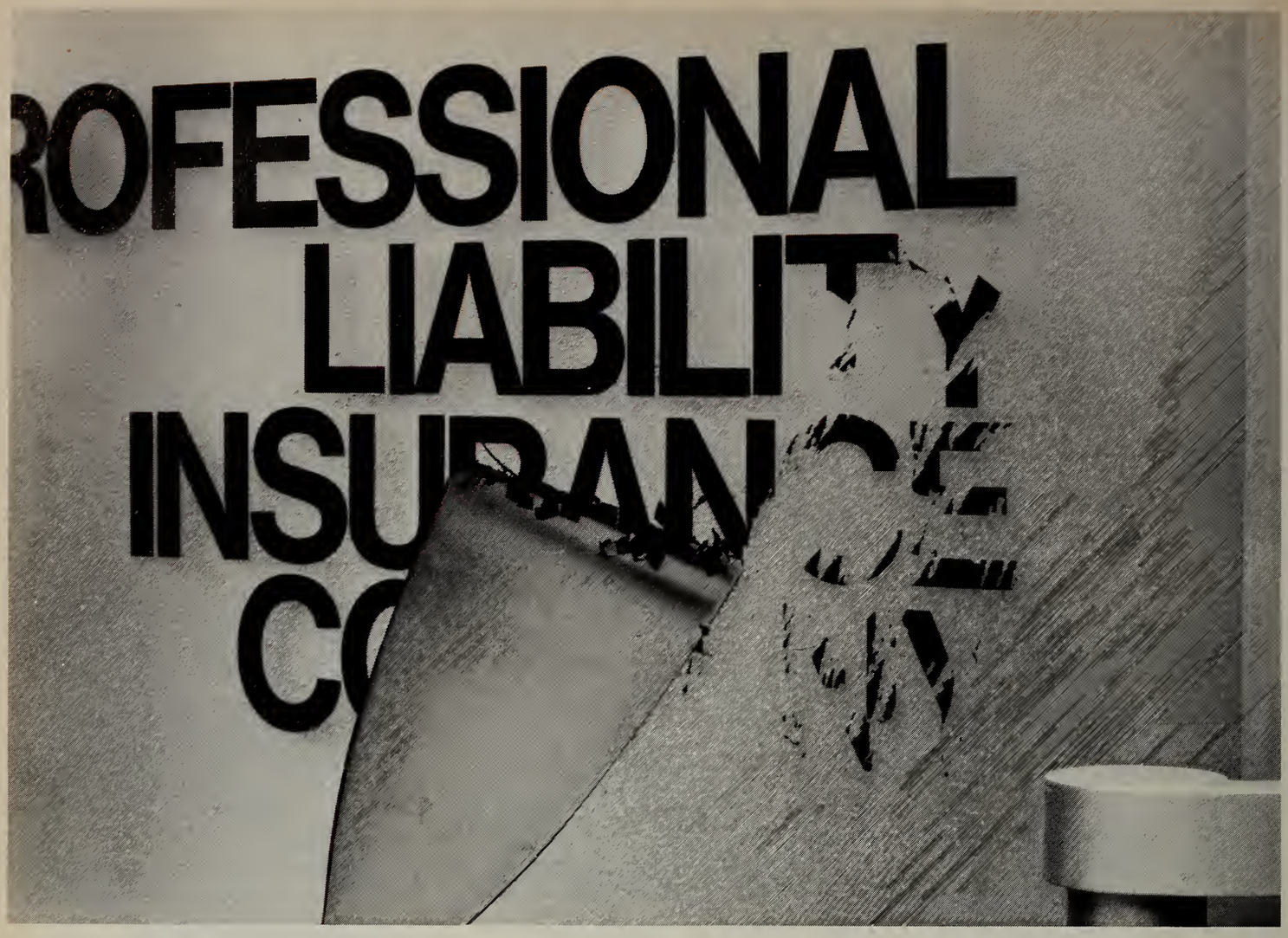
RSV poses a special threat to children under the age of two because it can lead to severe respiratory diseases such as pneumonia.

No new policies

St. Paul Insurance, the country's largest commercial writer of malpractice insurance, recently announced that effective immediately it will not write any new policies for physicians, hospitals, nursing homes, or other health care providers.

This announcement should not affect current St. Paul policyholders, although the company has estimated that its professional liability premium rates will increase by 45%.

St. Paul Insurance, which handles only claims-made policies, has not indicated price increases for excess levels.



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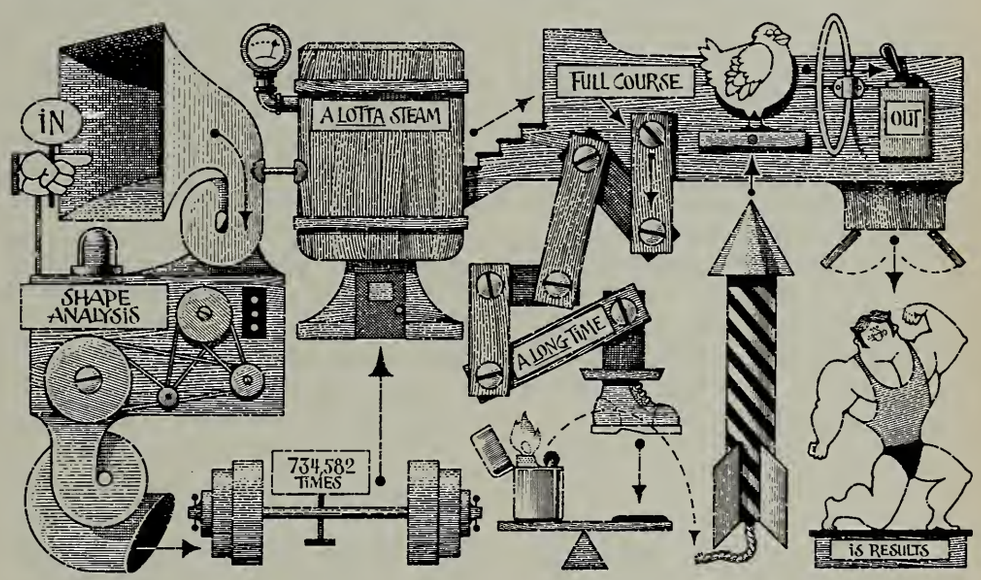
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Ohio medi-scene

Exercise and osteoporosis . . . determining child abuse . . . AIDS in the healthcare workplace . . . reserving skilled care beds . . . Cleveland doctors donate blood

Exercise: A new treatment for osteoporosis?



The theory goes like this: exercise, that "regular pastime" you've been prescribing to patients for years, may be doing a lot more for them than merely strengthening their muscle tone and relieving the effects of stress. New evidence now indicates that exercise may also be responsible for increasing bone strength and density as well — a theory which, if proven correct, may have a significant impact on the treatment of osteoporosis.

But the theory is a difficult one to test. After all, patients whose bones have been considerably weakened over the years hardly seem like likely candidates to be sending out to suburban jogging trails.

"Even walking is not without hazards for some patients," agrees Drue Denton, MD, who treats a number of osteoporosis patients in his internal medicine practice at the University of Cincinnati Medical Center.

But knowing that the theory exists makes it difficult to restrict treatment to the increased calcium diet and estrogen therapy which are traditional treatments for this disease. Although Dr. Denton is quick to point out that both of these traditional therapies *are* important, he couldn't resist the temptation to provide *his* osteoporosis patients with something more — a chance to test the theory that exercise might help improve their condition.

"I had been looking for several years, anyway, for an exercise program which I could recommend to all my patients," says Dr. Denton. The new research simply prompted him to broaden his search, and it was finally two factors which convinced him to focus his investigations in a single direction: 1) a study which showed that weightlifters were the class of athletes with the strongest bones and 2) the fact that he had recently started a weight-training program on his own.

"I know how much stronger I felt as a result of my own weight-

Ohio medi-scene . . . continued

Exercise and osteoporosis . . . *continued*

training," says Dr. Denton, "and combined with the study on the weightlifters, it just seemed to me there must be some way we could develop a weightlifting program for osteoporosis patients."

Considering the fact that most osteoporosis victims are post-menopausal women, however, the suggestion, at first, seemed ludicrous.

"But look at the facts," says Dr. Denton. "Osteoporosis starts in the upper body and progresses to the lower spine. Women, as a general rule, don't get much exercise for their upper body."

In fact, most women don't get much exercise at all, since "it's only been recently that society has approved of strong women. Before that, women were supposed to be frail and delicate," Dr. Denton notes. This lack of exercise, then, may be *why* women are the likeliest victims of this disease — but although weightlifting may be just what the doctor *should* order for these patients, Dr. Denton knew that an ordinary weight-lifting program was not going to be suitable.

That's why, this past spring, he traveled to Florida to visit with the people at Nautilus — one of the most prominent names in the weight-training business. He was hoping for answers — and he got them.

"I found out that Nautilus was working with the University of Florida on a ten-year study of the effect of exercise on osteoporosis," says Dr. Denton.

That study is now in its third year, and has shifted its focus from a study of post-menopausal women to pre-menopausal women.

"The researchers are now studying what happens *before* the bone begins to deteriorate," says Ken Hutchins, a staff member at Nautilus who is involved in the studies. Theoretically, there is a "peak period" of bone growth, he says. But, after the age of 35, a major decline in bone structure takes place. If the bones are strong before that period, osteoporosis will have little effect.

"We're attempting to determine what happens when mass is added during the 'peak bone' period. If there is more bone there to deteriorate, will it slow down the effects of osteoporosis?" asks Hutchins.

It's too early to draw any conclusions, but the study interested Dr. Denton.

"In order to accommodate these patients, Nautilus redesigned their equipment so it could be used at a lower starting weight — 20-pound rather than the 30-pound starting weight used by most athletes," says Dr. Denton. "And they developed a super-slow technique for lifting those weights."

Deeming it safe, Dr. Denton took the program back to Cincinnati with him, and set it up at the Walter L. and Nell Gross branch YMCA in Woodland.

As far as can be determined, this is the first time the program has been offered publicly, and the public is turning out in surprisingly large numbers to participate.

"I'd say we have had close to 100 participants since we opened in September," says Juanita Barkley, who is program director at the Gross YMCA.

Ages of participants range from 17 to 85, and they come from as far away as Kentucky and Indiana. Educational levels and backgrounds vary as well — as do handicaps, since arthritis victims also benefit from the program's activity.

"We provide a supportive atmosphere for these people," says Barkley, who says that participants are never pushed along, and never embarrassed by what they can and cannot do. "We teach them to retain their sense of humor," she explains.

Patients begin with the 20-pound weight and are taught what Barkley describes as ten-second lifting. "We tell them to lift very slowly, counting one-one thousand, two-one thousand, until they reach ten. Then they pause one count, and lower the weight back down to the ground."

"That's about as slow as you can go in weightlifting while continuing to maintain a smooth, non-jerky movement," adds Dr. Denton.

Once patients have mastered the technique, and can repeat it eight times in good form, they graduate to heavier weights.

"We increase the weight by five percent until the patient is able to lift 50 pounds comfortably," says Dr. Denton. Then, the weight is increased by 10 percent.

It's the super-slow technique that keeps the activity from becoming dangerous — no matter what *weight* is being lifted, says Dr. Denton.

"The super-slow technique takes the weight-bearing off the knees,

hips and feet so that the stress on ligaments, tendons and bones is considerably reduced," says Dr. Denton.

Yet each muscle group still receives a good workout, he adds.

One sideline benefit of bringing this technique to his patient's attention is that they, in turn, are bringing it to the attention of their families.

"The patient will come to exercise, then, after awhile, her husband will join her to work out on the equipment himself. Pretty soon, the son or daughter show up, and they bring their brothers or sisters; so, before long, the whole family is in here exercising," explains Dr. Denton.

And he's all for it, he says, because he believes that the earlier a person — especially a teen-aged girl — begins to exercise, the better chances he or she has of avoiding a similar problem in the future.

"I see exercise as not only a way to treat osteoporosis, but as a way to prevent it," he says.

Does he have any proof that his exercise program is doing any good?

"It's too soon to tell," he acknowledges, admitting that he has not yet gone back to re-measure the bone density of patients participating in the program.

"Bone density changes very slowly," he says, but in one to two years we *will* go back and re-measure density — the same way that the University of Florida will be measuring the effect of exercise on the bone strength of its participants in the future.

Until then, Dr. Denton is content with the non-scientific results of his study to date.

"The exercise is not harming the patients and there has been a demonstrated increase in their strength and the range of motion in their joints," he says.

"And psychologically, their outlook is much brighter," adds Barkley. She points out that simply socializing with others who have the same medical problem can be a positive, supportive experience.

"And family members are telling me how much more the patient is getting around, and how much better they're getting around," she says.

Dr. Denton is now looking for a program which will combine the weightlifting exercises with rowing machine activity — "for aerobic fitness," he explains, and he is anxious to see his exercise program expand to other areas.

"Once the program has been well-defined at the Gross YMCA, we'll be looking to expand it into other Y branches around the city, maybe even the county," says Dr. Denton, pointing out that it will obviously be more convenient for patients to exercise in a facility that's close to them.

But it's more than a convenience factor to Dr. Denton. It's the opportunity of being able to provide others with osteoporosis a new treatment — along with a new hope for the future — that he ultimately finds most appealing. — *Karen S. Edwards*

Is it child abuse? New kit may help you decide . . .

Two Columbus researchers have developed a kit that allows you an opportunity to test your skills in detecting child abuse.

Charles Johnson, MD, and Jacy Showers, EdD, of Children's Hospital, have put together a kit which presents actual photographs of bruised children, and then asks the physician whether child abuse is depicted.

According to an article which appeared in the *AM News,* the kit shows physicians how to keep better records and points out the physician's own biases toward child discipline. (Belt or buckle marks may go unnoticed, for example, since some people do not consider whipping with a belt as abuse, says the researchers.)

Patient records should include an injury's size, shape, and age, as well as the parent's interpretation of how the injury occurred, the researchers say.

The $40 self-paced testing program takes about four hours to complete, and teaches the physician how to spot the most common sign of abuse, the three types of fractures indicative of abuse, and the most common sites of injury in childhood accidents.

Here's a hint — most of the photographs contained in the kit *are* of abused children.

Ohio medi-scene . . . continued

AIDS in the health care workplace

"AIDS is not very contagious — but AIDS hysteria is." And both can result in a variety of problems in the workplace, according to J. Alan Lips, Esq., a partner in the Cincinnati law firm of Taft, Stettinius & Hollister.

Lips spoke at a special seminar on "The AIDS Dilemma" sponsored by the Greater Cincinnati Hospital Foundation last January. Aimed chiefly at the business community, the purpose of the seminar was to help employers deal with both the disease and the hysteria — along with the medical and legal aspects of AIDS.

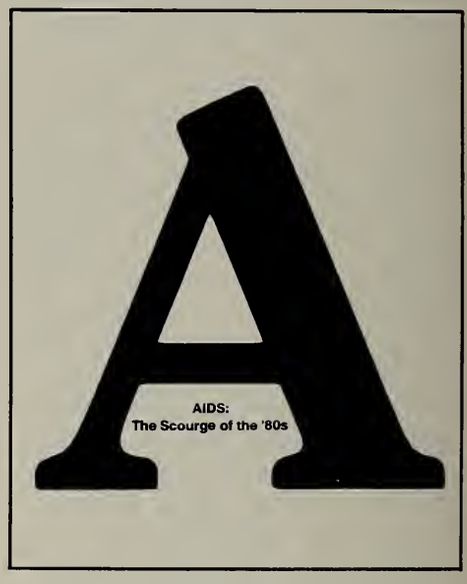
And the health care workplace is by no means immune to this problem, Lips pointed out. In fact, health care workers are one of the four groups Lips classified as most affected by the AIDS dilemma. "Nurses work with needles and give shots to AIDS patients every day," he said. "There is a strong suggestion that we must protect nurses and other employees from sticking themselves with needles just pulled out of AIDS patients."

Today, thousands of physicians, nurses and other health care workers come into regular contact with AIDS patients, Evelyn Hess, MD, chairperson of the Greater Cincinnati AIDS Task Force and director of the division of immunology at the University of Cincinnati College of Medicine, pointed out during the seminar. "But to date, no health care worker in this country has developed AIDS from treating these patients."

As of October 19, 1985, some 1,758 health care workers in the U.S. had been given the HTLV-III antibody test to check for the presence of the AIDS virus, reported Carol Kauffman, MD, chief of the infectious disease section at Ann Arbor (Michigan) Veterans Administration Medical Center and professor of internal medicine at the University of Michigan Medical School. All of these workers had had some direct contact with AIDS patients or AIDS-infected substances, such as accidentally pricking themselves with needles used on AIDS patients or being splashed in the face with AIDS-contaminated blood.

Approximately 1.5% of those tested, or 26, tested positive to the antibody test; however, 23 of the 26 belonged to one of the high-risk groups most susceptible to AIDS: homosexual men, intravenous drug users and hemophiliacs. Thus, it was determined they were infected by another source.

It is still uncertain exactly how the other three may have contracted the virus, according to Dr. Kauffman. "One was an anonymous donor, so it was impossible to follow up on that case," she reported. Another was a nurse, and the third worked in a blood bank. Since neither had been tested for the virus prior to that point, it is difficult to tell when they actually were exposed, she said. "These two possibly contracted the AIDS virus through their occupations," she said. To date, however, neither of them has



shown any symptoms of AIDS.

Such was not the case, however, in another incident which took place out of this country. According to an article in *Time* magazine, a British nurse appears to have been infected with the AIDS virus after accidentally sticking herself with a needle used on an AIDS patient, Dr. Kauffman reported. The nurse was given the antibody test immediately after the incident and tested negative to the virus, Dr. Kauffman said. However, she soon developed mono-like symptoms, which disappeared after about two weeks. At that point, she was again tested and the results were positive. "But she did not get AIDS," Dr. Kauffman stressed.

"AIDS is a clinical diagnosis," she continued, and there are still no diagnostic tests available to pinpoint the disease. Until the patient develops any of several opportunistic infections or a

related disorder such as Kaposi's Sarcoma, the patient cannot be diagnosed as having AIDS.

Rather, those patients who show a positive reading on the HTLV-III antibody test and suffer from fever, night sweats, swelling in the neck, fatigue, weight loss, etc., have AIDS-Related Complex (ARC), Dr. Kauffman explained. Others are asymptomatic — they have the virus in their blood but have no symptoms of AIDS. To date, studies show that around 29% of ARC patients go on to develop AIDS, but that figure could change because the virus has an unusually long — six-month to seven-year — incubation period.

Because of the many uncertainties that surround the AIDS virus, Lips urged hospital and health care administrators and others in business and industry to take every precaution necessary to protect their employees from the AIDS virus — and themselves from liability. "From a legal point of view, you do well to engage in protective measures from your health care workers," he said.

In order to help stop the spread both of the disease and the hysteria, employers should plan ahead for the day when their workers may be exposed to the virus, according to Lips. "Every employer should develop a plan of action for dealing with AIDS related problems," he said. "Such a plan should include at least the following four procedures:

"1. Articulate your policy — Each employer must look to the risks within their own workplace.

"2. Educate your workers. A court called AIDS 'the modern equivalent of leprosy.' Controlling the emotional response to AIDS is a greater challenge than controlling its contagiousness. Tell your workers before an incident arises that the latest medical evidence indicates the risk of transmitting AIDS — even in health care work settings — is low. Once workers accept this medical evidence, much of the hysteria and consequent legal risk will diminish.

"3. Implement and publicize precautions. Employers should implement and use visible appropriate safety procedures and protective equipment, both to lower the risk of spreading AIDS and to let workers know their employer is protecting them.

"4. Develop protocols to handle AIDS crises. Ideally, when an AIDS crisis hits the workplace, management should react by planned stages. Overreaction leads to mistakes, lawsuits and liability."

According to Dr. Kauffman, approximately 400 health care workers in the U.S. currently suffer from AIDS, and while they may not have obtained the disease in the workplace, they can present potential problems at work. Again, the legal issues surrounding the rights and risks of an AIDS employee remain largely unanswered, said Lips.

"As the recognition of the AIDS problem grows, it spawns new legal issues such as: Is warning co-workers of an employee's AIDS infection an invasion of privacy? When is firing an AIDS victim 'wrongful discharge' or discrimination? When is AIDS, AIDS-Related Complex or the AIDS virus a protected handicap? Is AIDS an unprotected disease or a protected disability under the handicap statutes? When is AIDS in a workplace a hazard under federal safe-workplace laws? When is an employee afflicted with AIDS entitled to workers' compensation? What labor bargaining obligations arise when an employer decides to test workers for AIDS? It is essential that employers consult their legal counsel for assistance in dealing with these heretofore unanswered questions?"

Meanwhile, says Dr. Kauffman, a number of precautions can be taken to ensure that AIDS is not spread in the health care environment. "Fortunately, the virus is easily inactivated in the environment," she said. "You can use a variety of agents — bleach, alcohol, ethylene oxide and even heat" to kill the AIDS virus outside the body, she said.

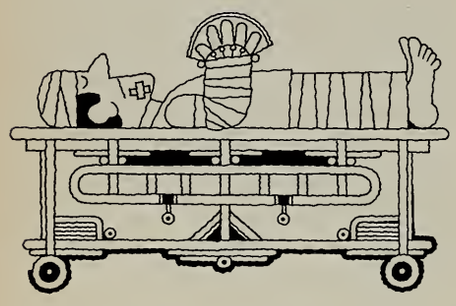
Hospitals, labs, etc., should emphasize infection control procedures and should urge employees to take precautions: avoid needle-stick incidents and wear protective clothing when coming into direct contact with the blood or body fluids of an AIDS patient. Signs warning health care workers to take precautions when handling these blood and body fluids might also be posted near the patient.

However, it is not appropriate to wear a mask and gloves when coming into casual contact with an

Ohio medi-scene . . . continued

AIDS in the workplace
continued

AIDS patient or to post a large "AIDS" sign on the patient's door. "These are real people suffering from a real and fatal disease, and they should be treated accordingly," she said. — *Susan Porter*



"No dumping"

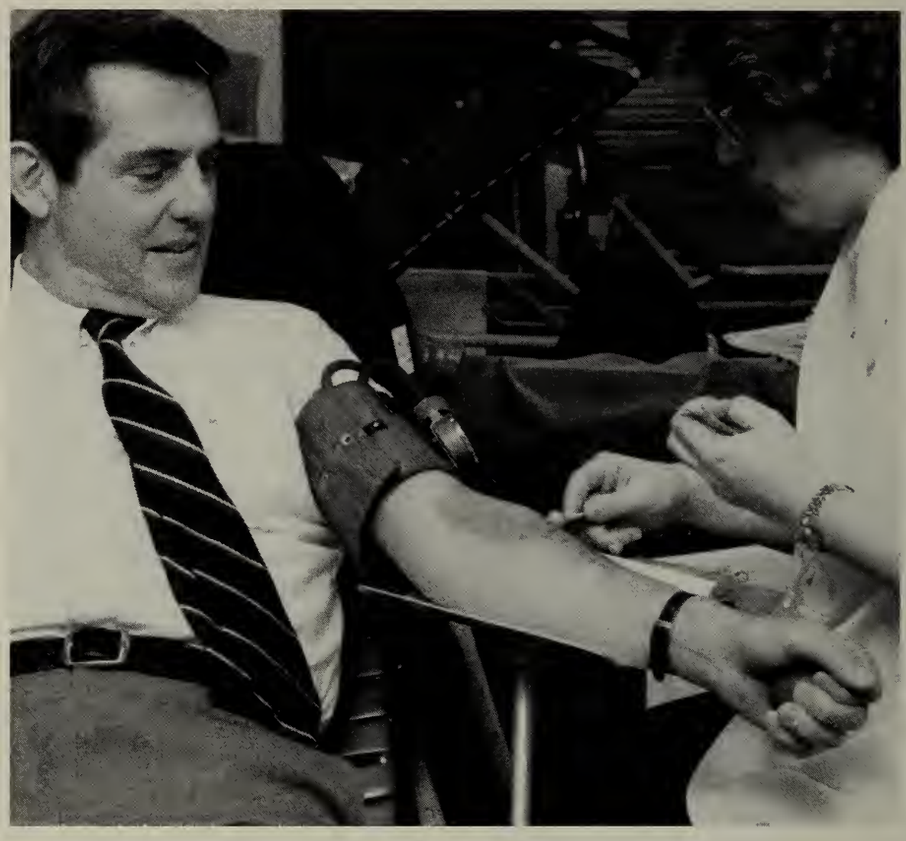
The Cleveland Clinic isn't dumping any Medicare patients out of *its* beds — DRGs or not.

Last year, the Clinic placed four beds on reserve at a nearby skilled nursing home to receive those patients who may need more time to recover than that normally allotted by the prospective payment system. For each bed the hospital does *not* fill, it pays the nursing home $65.

According to an article that ran in *Medical World News,* the bed-reservation agreement in Cleveland is one of a growing number of arrangements being made to quickly relocate patients who still need care, but not the acute type of care offered by hospitals.

"We need to develop a series of interventions that lie between acute care and home care," sociologist Abraham Brickner, director of health services research and program development at the Cleveland Clinic was quoted as saying.

Health and Human Services approved coverage for the program last spring, and about 60 patients have been transferred so far. But it has taken a while for physicians to catch on and make timely referrals, says Brickner; so, financially, the program is just breaking even. However, the Clinic's medical staff is now seeking out potential transfers earlier, so the program's profitability could grow as a result, the article adds.



Cleveland physicians donate blood

A Red Cross nurse prepares Hermann Menges, Jr., MD, president of the Academy of Medicine of Cleveland, to donate blood during a special Doctors' Blood Drive held at the Academy's headquarters in February. Purpose of the drive was to help increase blood resources by dispelling the fear of contracting AIDS by donating blood.



Special Section
1986 ANNUAL MEETING
May 2-4, 1986
Dayton, Ohio

Special Section Contents

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Members of 1986 House of Delegates 238
Continuing Medical Education Courses 245
OMPAC Luncheon 250
Social Event — "The Spring Fling" . . . . . Insert
Reservation Form 260

IMAGINE



We're putting the best minds to work on Alzheimer's.

Outstanding care for Alzheimer's patients is now closer at hand, thanks to the opening of the Alzheimer's Center at Mount Carmel.

This uniquely comprehensive resource would not be a reality without the vision and pioneering spirit of our medical staff.

This year we're celebrating a century in health care. Looking back, we can see many areas where Mount Carmel Health physicians have set the pace. In cardiology, orthopedics, gerontology and oncology. In trauma care. And in the treatment of diabetes.

Now, with the Alzheimer's Center, our medical staff will be at the forefront in exploring facets of the mind that have long surpassed the mind's understanding.

MOUNT CARMEL HEALTH

CENTENNIAL CELEBRATION
1886-1986

A MEMBER OF THE HOLY CROSS HEALTH SYSTEM

OSMA Annual Meeting

May 2-7, 1986

Candidate for President-Elect

D. Ross Irons, MD



D. Ross Irons, MD

Dear Mr. Gillen:

The Huron County Medical Society is pleased to nominate D. Ross Irons, M.D., of Bellevue, Ohio, as candidate for the office of President-Elect of the Ohio State Medical Association. The Huron County Medical Society takes pride in the fact that Dr. Irons has demonstrated his leadership abilities in a forthright and aggressive manner. At the June meeting of the Huron County Medical Society, his candidacy was enthusiastically endorsed.

Dr. Irons is currently Chief of Surgery at the Bellevue Hospital as well as being on the courtesy surgical staff at four other area hospitals. He is past president of Bellevue Hospital Medical Staff. He represents the Bellevue Hospital as its Cancer Liaison Fellow to the American College of Surgeons. Dr. Irons has served two terms on the Board of Trustees of the Bellevue Hospital, and in his final year served as Chairman of the Board. At the county level, Dr. Irons has served as president of our society, has been program chairman, and has represented our county at the OSMA annual meeting as both delegate and alternate delegate.

Our candidate is currently Councilor representing the Northwest District of the Ohio Chapter of the American College of Surgeons.

At the state level, Dr. Irons currently serves the 11th District as Councilor, and at the OSMA level has served on numerous committees and task forces. He is on the Auditing and Appropriation Committee, the Task Force on Professional Liability, and the Task Force on Communications. In the past he has served as chairman of the Task Force on Health Care for the '80s. Dr. Irons concomitantly served as the OSMA's representative to the Governor's Task Force on Health Care Costs.

At the community level, Dr. Irons serves as a director of the Bellevue Chamber of Commerce and is currently president of the Bellevue Area Development Corp.

The officers and members of the Huron County Medical Society feel our nominee is well suited for the office of President-Elect of the Ohio State Medical Association.

Sincerely,
Deborah K. Franley, M.D.

Dr. Irons received his medical degree from Ohio State University College of Medicine in 1960, after first receiving a BS in Pharmacy from Ohio Northern University, and completing graduate work in anatomy at Oberlin College. Following his internship at Akron General Medical Center, Dr. Irons stayed with the hospital to complete a residency in general surgery, serving as chief administrative resident during his final year in the program. Now, a licensed physician, surgeon and pharmacist, Dr. Irons presently has a private practice in general surgery in his hometown of Bellevue, and serves as Chief of Surgery at Bellevue Hospital. He is also affiliated with Memorial Hospital of Sandusky County in Fremont, Providence Hospital and Good Samaritan Hospital, both in Sandusky, and Fisher-Titus Memorial Hospital in Norwalk. He also serves on the consulting surgery staff at Willard Area Hospital in Willard, Ohio.

Dr. Irons's hospital work extends beyond normal duties, however, to include two terms on Bellevue Hospital's Board of Trustees (one of which he spent as Chairman of the Board); two terms as president of Bellevue Hospital's medical staff; and a position as cancer liaison physician at Bellevue Hospital, a responsibility he has held from 1984 until the present.

Of course, Dr. Irons's work with the OSMA has been just as active and just as varied. In addition to serving two years both as a delegate and an alternate delegate to the House, he has served as 11th District Councilor from 1982 until the present. Since he has always been willing to tackle the more difficult issues facing medicine, he has been regularly assigned to OSMA task forces and committees which deal with these kinds of "hotbed" issues, including two terms as Chairman of the OSMA's Task Force on "Health Care for the '80s"; the task force on professional liability; and on the OSMA Committee which is working to revise the Nurse Practice Act, currently before the state legislature. In addition, he was one of several members who represented organized medicine on the Governor's Commission on Health Care, which ran from April, 1982 until June, 1984. His concern with organized medicine and the OSMA is also reflected in his position on the OSMA's Long Range Planning Committee on membership strength and financial stability. He has also served as a board member of OSMA's affiliated company, PACO, since 1984.

On the local level, Dr. Irons has served as president of the Huron County Medical Society, and he has been active at both the state and national levels of his specialty society — the American College of Surgeons. His hometown recently recognized his services with the Bellevue Development Corporation (including a term as president), by presenting him with Bellevue Chamber of Commerce's distinguished service award.

Dr. Irons lives in Bellevue with his wife, Rebecca, and three of their six children.

MEDICINE: WHERE DO WE GO FROM HERE?

OSMA Annual Meeting

May 2-7, 1986

Delegates and Alternates Schedule

FRIDAY, MAY 2

3:00-7:00 PM
Registration for OSMA House of Delegates
Skyway, Dayton Convention Center

4:00 PM
Councilor District Caucuses
Locations will be posted at the Registration Desk

6:00 PM
Dinner for Delegates, Alternates, OSMA Council and Official Guests
Van Cleve Ballroom, Stouffer Dayton Plaza Hotel

7:00 PM
Opening Session, OSMA House of Delegates
Ballroom, Main Lobby, Dayton Convention Center

BUSINESS AGENDA OPENING SESSION

Call to Order
Herman I. Abromowitz, M.D., Dayton
President

Invocation
Thomas J. Diehl, S.J.
St. Xavier Church, Cincinnati

Welcome
Blaine L. Block, M.D., Dayton
President, Montgomery County Medical Society

Parliamentarian
W.J. Lewis, M.D., Dayton

Report
Committee on Credentials

Consideration of Minutes of 1985 Annual Meeting
(See August 1985 issue of The Ohio State Medical Journal)

Introduction of Member, AMA Board of Trustees

Introduction of Honored Guests

PICO Report
John J. Gaughan, M.D., Cleveland
Chairman of the Board

O.M.E.R.F. Report
Oscar W. Clarke, M.D., Gallipolis
Chairman of the Board

Membership Outreach Program
Thomas W. Morgan, M.D., Gallipolis
Chairman

Auxiliary Report
Mrs. Diana Talmage, Toledo
OSMA Auxiliary President

AMA-ERF Presentations
Philip B. Hardymon, M.D., Columbus
Chairman, Ohio Committee on AMA-ERF

Presentation of Plaques
To past Councilors, retiring AMA Delegates and Alternates and Chairmen of Committees

Announcement
Herman I. Abromowitz, M.D.
Appointments to Resolutions Committees, Credentials, and Tellers and Judges of Election Committees

Election of Committee on Nominations
Nominations from the floor. One representative (delegate) from each Councilor District. The committee shall report to the second and final session, Sunday, May 4, 1:00 p.m., its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws. Under the rotation plan established in 1963, the committeeman from the First District shall serve as Chairman. The report of the Nominating Committee with respect to all offices except President-Elect shall be posted at the registration desk, earliest time practicable and at least three hours before the final session of the House of Delegates.

Presidential Address
Herman I. Abromowitz, M.D.

Introduction of Presidents of Other State Societies

Introduction of Representatives of Allied Organizations

Special Order of Business
Memorial Resolutions

Introduction of Resolutions
Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Sunday afternoon session before any action can be taken.

Committee on Emergency Resolutions Report

Miscellaneous Business

SATURDAY, MAY 3

7:00-8:00 AM
Buffet breakfast for Delegates, Alternates, OSMA Council and Official Guests
Van Cleve I and II, Stouffer Dayton Plaza Hotel

8:00-11:30 AM
Reference Committee Hearings, Dayton Convention Center

Resolutions Committee No. 1	Room 302
Resolutions Committee No. 2	Room 303
Resolutions Committee No. 3 & President's Address	Room 202
Nominating Committee	Room 306

SUNDAY, MAY 4

8:00 AM
Councilor District Caucuses
Caucus locations will be posted at the Registration Desk

11:30 AM-1:00 PM
Registration for OSMA House of Delegates
Main Lobby, Dayton Convention Center

6:00 PM
Dinner for Delegates, Alternates, OSMA Council and Official Guests
Van Cleve Ballroom, Stouffer Dayton Plaza Hotel

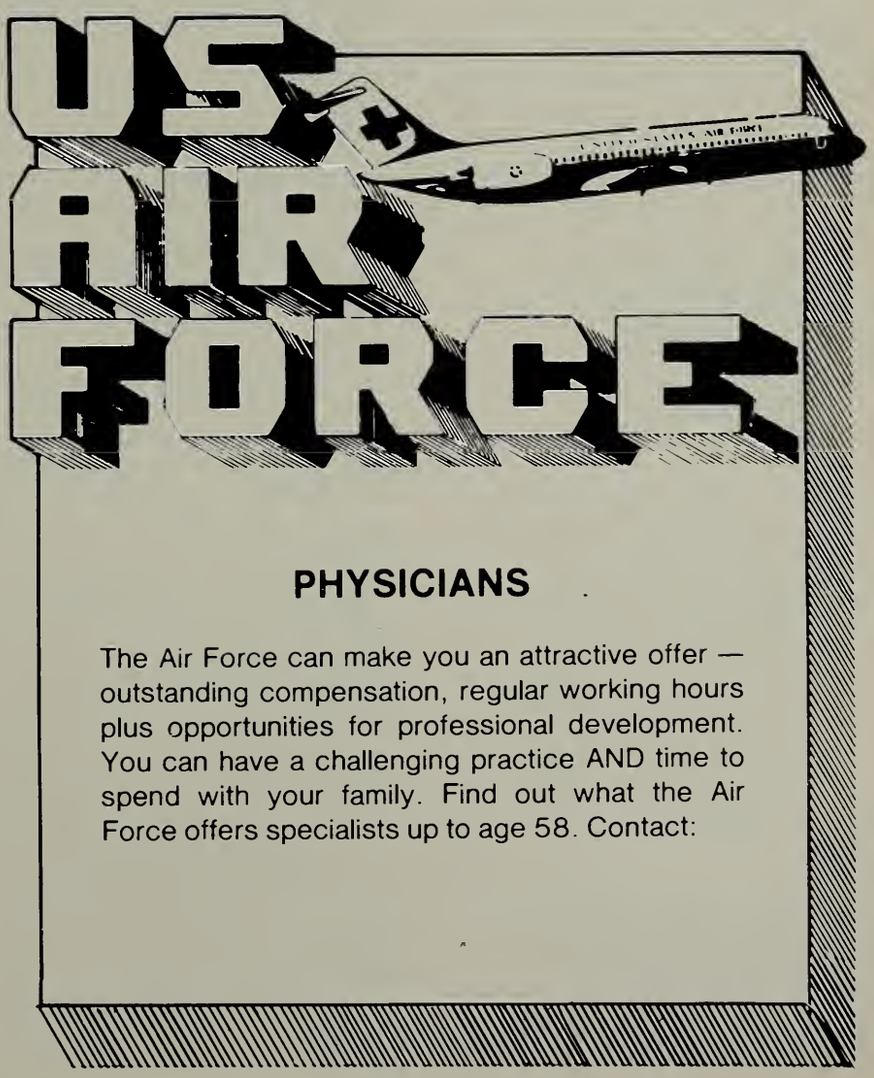
7:00 PM
Continuation of Final Session

ORDER OF BUSINESS FINAL SESSION

Introduction of Guests
Report of Committee on Credentials
Election of President-Elect
Report of Committee on Nominations and Election of Other Officers
Election of Members of The Council
Members of The Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in even-numbered years. First District: Incumbent, Stanley J. Lucas, Cincinnati; Third District: Incumbent, Thomas R. Leech, Lima; Fifth District: Incumbent, Donavin A. Baumgartner, Jr.; Cleveland; Seventh District: Incumbent, Nermin D. Lavapies, Martins Ferry; Ninth District: Incumbent, Thomas P. Price, Jr., Gallipolis; Eleventh District: Incumbent, D. Ross Irons, Bellevue.
Election of Delegates and Alternates to the AMA
Eight Delegates and eight Alternates to be elected for a two-year term starting January 1, 1987, in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates and Alternates will serve for the remainder of 1986, their terms expiring December 31, 1986.
Delegates (listed alphabetically): Theodore J. Castele, Cleveland; Stewart B. Dunsker, Cincinnati; Jerry L. Hammon, Dayton; Thomas W. Morgan, Gallipolis; H. William Porterfield, Columbus; Jack Schreiber, Canfield; Robert N. Smith, Toledo, and Robert G. Thomas, Elyria. Also, one additional Delegate to be elected for a term commencing May 4, 1986 and ending December 31, 1987.
Alternates (listed alphabetically): A. Robert Davies, Troy; Roland A. Gandy, Jr., Toledo; Edward G. Kilroy, Cleveland; Henry G. Krueger, North Olmsted; S. Baird Pfahl, Jr., Sandusky; Joseph Sudimack, Jr., Warren; Lee J. Vesper, Cincinnati; Claire V. Wolfe, Dublin. Also, one additional Alternate to be elected for a term commencing May 4, 1986 and ending December 31, 1987.
All nominees for the offices of AMA Delegates and Alternate Delegates of the AMA shall be governed by Section 7, Chapter 5, of the OSMA Constitution and Bylaws as revised by the House of Delegates in May 1971.

SPECIAL ORDER OF BUSINESS

Installation of 1986-87 Officers
Reports of Reference Committees
Resolutions Committee No. 1;
Resolutions Committee No. 2;
Resolutions Committee No. 3 and
President's Address
Miscellaneous Business
Announcement
John E. Albers, M.D., Cincinnati
President
Unfinished Business
Adjournment



MEDICINE: WHERE DO WE GO FROM HERE?

OSMA Annual Meeting

May 2-7, 1986

ANNUAL MEETING FORMAT

FRIDAY, MAY 2

OSMA INFORMATION DESK
9:00 AM-3:00 PM
Main Lobby, Stouffer Dayton Plaza Hotel

OSMA COUNCIL MEETING/ BREAKFAST
8:30 AM
Van Cleve II, Stouffer Dayton Plaza Hotel

HOSPITAL MEDICAL STAFF SECTION MEETING
9:00 AM
Banquet Hall Assembly, Dayton Convention Center

EMERGENCY RESOLUTIONS COMMITTEE LUNCHEON
12:00 Noon
Van Cleve III, Stouffer Dayton Plaza Hotel

OSMA DELEGATION TO AMA MEETING
1:00 PM
Dayton Room, Stouffer Dayton Plaza Hotel

HOUSE OF DELEGATES
3:00-7:00 PM
Registration, Skyway, Dayton Convention Center
6:00 PM
Sit-down Dinner, Van Cleve Ballroom, Stouffer Dayton Plaza Hotel
7:00 PM
Opening Session, Ballroom, Dayton Convention Center

COUNCILOR DISTRICT CAUCUS MEETINGS
4:00-5:30 PM
Locations to be posted at Registration Desk

FOLLOWING HOUSE OF DELEGATES
Montgomery County Glee Club
Theater, Dayton Convention Center
All-member Reception hosted by Montgomery County Medical Society

SATURDAY, MAY 3

REFERENCE COMMITTEES
7:00 AM
Breakfast, Van Cleve I & II, Stouffer Dayton Plaza Hotel
8:00-11:30 AM
Hearings, Dayton Convention Center
Committee No. 1, Room 302
Committee No. 2, Room 303
Committee No. 3 & President's Address, Room 202
Nominating Committee, Room 306

GENERAL REGISTRATION
8:00 AM, Skyway, Dayton Convention Center

OMPAC
11:15 AM-1:30 PM
Social Hour & Luncheon
Van Cleve Ballroom, Stouffer Dayton Plaza Hotel

WRIGHT STATE UNIVERSITY SCHOOL OF MEDICINE PROGRAM
1:45-4:45 PM
Theater, Dayton Convention Center

SPRING FLING GALA
7:00 PM
Social Hour hosted by Community Mutual Insurance Company
8:00 PM
Dinner catered by the famous Benham's (see insert for reservation form)
Banquet Hall, Dayton Convention Center

SUNDAY, MAY 4

GENERAL REGISTRATION
8:00 AM
Skyway, Dayton Convention Center

COUNCILOR DISTRICT CAUCUS MEETINGS
8:00 AM
Locations to be posted at Registration Desk

HOUSE OF DELEGATES
11:30 AM
Registration, Main Lobby, Dayton Convention Center
1:00 PM
Final Session, Ballroom, Dayton Convention Center
6:00 PM
Dinner, Van Cleve Ballroom, Stouffer Dayton Plaza Hotel
7:00 PM
Resume Final Session (if necessary)
Ballroom, Dayton Convention Center

MONDAY, MAY 5

GENERAL REGISTRATION
7:30 AM-5:00 PM
Skyway, Dayton Convention Center

OHIO COMMITTEE ON TRAUMA, A.C.S.
(Advanced Trauma Life Support provider course)
All functions at Miami Valley Hospital

NEUROLOGY
8:00 AM
Meeting, Room 302, Dayton Convention Center

GERIATRICS/GERONTOLOGY.
8:00 AM
Meeting, Room 303, Dayton Convention Center

PICO SHAREHOLDERS MEETING
10:00 AM
Room 203, Dayton Convention Center

OSMA COUNCIL MEETING/ BREAKFAST
8:30 AM
Van Cleve II, Stouffer Dayton Plaza Hotel

OHIO PSYCHIATRIC ASSOCIATION
9:30 AM — Council Meeting
Room 204, Dayton Convention Center

11:30 AM — Luncheon/Business Meeting
Plaza Suite N, Stouffer Dayton Plaza Hotel
1:30 PM — Scientific Session
Room 303, Dayton Convention Center

RHEUMATOLOGY
11:30 AM — Luncheon/Business Meeting
Van Cleve IV, Stouffer Dayton Plaza Hotel
1:00 PM-4:30 PM — Scientific Session
Room 302, Dayton Convention Center

WOMEN IN MEDICINE
1:00 PM
Room 202, Dayton Convention Center

NEUROSURGICAL
4:00 PM — Business Meeting
Rooms 304 & 305, Dayton Convention Center

PATHOLOGY
4:30 PM — Board Meeting
Room 307, Dayton Convention Center

TUESDAY, MAY 6

GENERAL REGISTRATION
7:30 AM-4 PM
Skyway, Dayton Convention Center

OHIO COMMITTEE ON TRAUMA, A.C.S.
(Advanced Trauma Life Support provider course)
All functions at Miami Valley Hospital

NEUROSURGICAL
7:30 AM-12:50 PM — Scientific Session
Room 203, Dayton Convention Center
1:00 PM — Luncheon
Van Cleve IV, Stouffer Dayton Plaza Hotel

PATHOLOGY
8:00 AM-5:00 PM — Scientific Session
Room 302, Dayton Convention Center

WESTERN OHIO PEDIATRIC SOCIETY
6:30 PM — Reception
7:00 PM — Dinner
8:00 PM — Meeting
Dayton Room, Stouffer Dayton Plaza Hotel

WEDNESDAY, MAY 7

GENERAL REGISTRATION
7:30 AM-3:00 PM
Skyway, Dayton Convention Center

ALLERGY & IMMUNOLOGY
8:00 AM-12:00 Noon — Scientific Session
Room 203, Dayton Convention Center
12:00 Noon — Luncheon
Van Cleve III & IV, Stouffer Dayton Plaza Hotel

PLASTIC SURGERY
9:00 AM-12 Noon — Scientific Session
Room 302, Dayton Convention Center
12:00 Noon — Luncheon
Dayton Room, Stouffer Dayton Plaza Hotel

DERMATOLOGY
9:00 AM-12 Noon — Scientific Session
Room 204, Dayton Convention Center

PHYSICAL MEDICINE AND REHABILITATION
12:00 Noon — Luncheon
Dayton Room, Stouffer Dayton Plaza Hotel
1:00-5:00 PM — Scientific Session
Room 303, Dayton Convention Center
6:30 PM — Dinner
Van Cleve II, Stouffer Dayton Plaza Hotel

MOVING

Notify The Journal Immediately

NEW ADDRESS:

Name

Street

City

State Zip

Send to:

Ohio State Medical Journal
600 S. High St.
Columbus, Ohio 43215

MEDICINE: WHERE DO WE GO FROM HERE?

OSMA Annual Meeting

May 2-7, 1986

MEMBERS OF 1986 OSMA HOUSE OF DELEGATES



FIRST DISTRICT

ADAMS COUNTY

Delegate:
Voravit Isaradisaikul
Alternate:
Bruce Ashley

BROWN COUNTY

Delegate:
John R. Donohoo
Alternate:

BUTLER COUNTY

Delegates:
Louis L. Barich
Alvin H. Niemer
John J. Ryan
Alternates:
Joseph H. Brandabur
David L. Bryant
Albert S. Palatchi

CLERMONT COUNTY

Delegate:
Carl A. Minning
Alternate:
William Blake Selnick

CLINTON COUNTY

Delegate:
H. Chung Tai Hu
Alternate:
Edwin P. Hiatt

HAMILTON COUNTY

Delegates:
Sabino T. Baluyot
Richard B. Budde
Ronald H. Fegelman
Harry H. Fox
Kenneth A. Frederick
William H. Gates
Stephen P. Hogg
K. William Kitzmiller
Edward J. Kremchek
Herbert G. Magenheim
Walter E. Matern
Robert J. McDevitt
William C. Miller
Harold Pescovitz
Daniel E. Santos
Lee J. Vesper
Thomas R. Werner
S. Marcus Wigser
Walter B. Wildman, II
Alternates:
I. Leonard Bernstein
Edmund C. Casey
Judith S. Daniels
Joe N. Hackworth
Thomas Helmsworth
Edmund W. Jones
David Marc Kesterson
W. John Kitzmiller
Herbert D. Long, Jr.
Kris Mahalingam
James E. Schmidt
Stanley J. Wacksman

HIGHLAND COUNTY

Delegate:

Alternate:

WARREN COUNTY

Delegate:
Thomas Fox
Alternate:
Jeffrey Baker



SECOND DISTRICT

CHAMPAIGN COUNTY

Delegate:
John H. Flora
Alternate:
J. Steven Polsley

CLARK COUNTY

Delegates:
Carlos Andarsio

Walter Lawrence
Alternates:
Paul Andorfer
William Harper

DARKE COUNTY
Delegate:
William S. Elliott
Alternate:
Daniel Berger

GREENE COUNTY
Delegate:
Shamin Shamsi
Alternate:
Manoj Desai

MIAMI COUNTY
Delegate:
A. Robert Davies
Alternate:
Jerry L. Hammon

MONTGOMERY COUNTY
Delegates:
Herman I. Abromowitz
John H. Boyles, Jr.
Gerald J. Broock
D. Kiefer Campbell
Stephen T. House
Richard G. Jenkins
Arlene Kagner
Alan H. Klein
Robert W. Lipp, Jr.
Walter A. Reiling, Jr.
Alternates:
Sean V. Convery
Arthur Gardikes
Harold G. Kelso, Jr.
Walter W. Keyes
Konrad F. Kircher
Warren F. Muth
W. Scott Nekrosius
Kasimir Oganowski
William K. Rundell
Edward W. Sachs, III
William D. Sawyer

PREBLE COUNTY
Delegate:
John D. Darrow
Alternate:

SHELBY COUNTY
Delegate:
Joseph Steurnagel
Alternate:
Edward A. Link



THIRD DISTRICT

ALLEN COUNTY
Delegates:
John D. Albertson
Lee W. Like
Alternates:
Hector A. Buch, Jr.
Richard L. Faler

AUGLAIZE COUNTY
Delegate:
Thomas C. Dozier
Alternates:
Robert P. Gill
Robert J. Herman

CRAWFORD COUNTY
Delegate:
Stephen Kim
Alternate:
John K. Kurtz

HANCOCK COUNTY
Delegate:
William H. Kose
Alternate:
Thomas L. Mount

HARDIN COUNTY
Delegate:
Filmore A. Riego
Alternate:
Leonard K. Smith

LOGAN COUNTY
Delegate:
James Steiner
Alternate:
Evan W. Dixon

MARION COUNTY
Delegate:
Paul E. Lyon
Alternate:
D. Lee Johnson

MERCER COUNTY
Delegate:
James J. Otis
Alternate:
Donald R. Fox

SENECA COUNTY
Delegate:
James A. Murray
Alternate:
Leonard M. Gaydos

VAN WERT COUNTY
Delegate:
Alford C. Diller
Alternate:
Thomas Lautzenheiser

WYANDOT COUNTY
Delegate:
Nasser J. Zohoury
Alternate:
Norman Cisar



FOURTH DISTRICT

DEFIANCE COUNTY
Delegate:
Benedict B. Lenhart

Alternate:
Paul E. Brose

FULTON COUNTY
Delegate:
David A. Thompson
Alternate:
Bernard B. Cohen

HENRY COUNTY
Delegate:
Wilson J. Stough
Alternate:

LUCAS COUNTY
Delegates:
Frank E. Foss
Roland A. Gandy, Jr.
John H. Hasley
B. Leslie Huffman, Jr.
James A. Jagodzinski
Jerome Kimmelman
Richard H. Koop
Howard S. Madigan
Antonio B. Paat
Lance A. Talmage
Richard J. Wiseley
Alternates:
John P. Anders
Ernest G. Brookfield
G. Mark Burton
Michael B. Gordon
David E. Hoover
Su-Pa Kang
Robert E. Kose
Robert J. Navarre, Jr.
Deirdre M. O'Connor
George M. Pipoly
William C. Sternfeld

OTTAWA COUNTY
Delegate:
Glenn Trippe
Alternate:

PAULDING COUNTY
Delegate:
Don K. Snyder
Alternate:
Kirkwood A. Pritchard

PUTNAM COUNTY
Delegate:
John R. Brown
Alternate:
James B. Overmier

SANDUSKY COUNTY
Delegate:
Robert J. Mowry
Alternate:

WILLIAMS COUNTY
Delegate:
John E. Moats
Alternate:
Robert Dilworth

WOOD COUNTY
Delegate:
Douglas S. Hess
Alternate:
Luana Hess



FIFTH DISTRICT

ASHTABULA COUNTY
Delegate:
Guy V. Jeanblanc
Alternate:
Richard S. Millberg

CUYAHOGA COUNTY
Delegates:
Karl S. Alfred
Charles P. Bartley, Sr.
Donavin A. Baumgartner, Jr.
Victor M. Bello
Charles M. Branden
Sheryl L. Buckley
John H. Budd
David M. Cahill
Theodore J. Castele
Salvatore J. Ciresi
James B. Daley
Daniel A. Deutschman
Stanley Fox
Richard B. Fratianne
John J. Gaughan
Gita Gidwani
Ray W. Gifford, Jr.
Thomas E. Gretter
Nancy K. Johnson
Donald W. Junglas
Edward G. Kilroy
Drue King, Jr.
Henry G. Krueger
George P. Leicht
Joseph P. Martin
Lawrence J. McCormack
Hermann Menges, Jr.
Richard J. Nowak
Bartholomew D. Ragucci
Robert V. Spurney
Peggy Jeanne St. Clair
Warner W. Tuckerman
Robert M. Zollinger, Jr.
Alternates:
Nabil F. Angley
Janet M. Blanchard
John A. Brown
R. Bennett Eppes
Richard S. Essig
Andrew J. Fishleder
Robert Kay
Louis Maggiore
Michael J. Papsidero
Charles A. Peck
Richard M. Steinhilber
Robert A. Wiltsie

GEAUGA COUNTY
Delegate:
Bruce F. Andreas
Alternate:
Robert Evans

LAKE COUNTY
Delegates:
John Bukovnik
E. Graham Lampert
Alternates:
Steven P. Combs
Joseph Myers

Have you reserved a room yet for the 1986 Annual Meeting? If not, the reservation form is on page 260.



SIXTH DISTRICT

COLUMBIANA COUNTY

Delegate:
William Banfield
Alternate:
John Madison

MAHONING COUNTY

Delegates:
J. James Anderson
J.C. Melnick
C. Edward Pichette
William E. Sovik
K.F. Wieneke
Alternates:
Thomas N. Detesco
Paul J. Mahar, Jr.
David E. Pichette
Juan A. Ruiz
Lloyd E. Slusher

STARK COUNTY

Delegates:
Robert DiSimone
George E. Ewing
Edward E. Grable
Raymond J. McMahon, Jr.
Robert C. Reed
Reich L. Watterson
Alternates:
James D. Burkholder
Andres B. Lao
Charles E. Smith
James Taddeo
Walter J. Telesz
David Utlak

TRUMBULL COUNTY

Delegates:
Joseph Sudimack, Jr.
John O. Vlad
Alternates:
Howard C. Adelman
Michael C. Thomas



SEVENTH DISTRICT

BELMONT COUNTY

Delegate:
Keith Y. Sohn
Alternate:
Nepomuceno Z. Dario, Jr.

CARROLL COUNTY

Delegate:
David Kukura
Alternate:
Donald Wingard

COSHOCTON COUNTY

Delegate:
Linda Magness
Alternate:
Donald Warren

HARRISON COUNTY

Delegate:
Elias Freeman
Alternate:
John Kuziak

JEFFERSON COUNTY

Delegate:
James Cottrell
Alternate:
Ronald Agresta

MONROE COUNTY

Delegate:
Jack M. Matheny, II
Alternate:
Donald R. Piatt

TUSCARAWAS COUNTY

Delegate:
Philip T. Doughten
Alternate:
Daniel Clemens



EIGHTH DISTRICT

ATHENS COUNTY

Delegate:
Gary Cordingley
Alternate:

FAIRFIELD COUNTY

Delegate:
Jayne W. Dye
Alternate:
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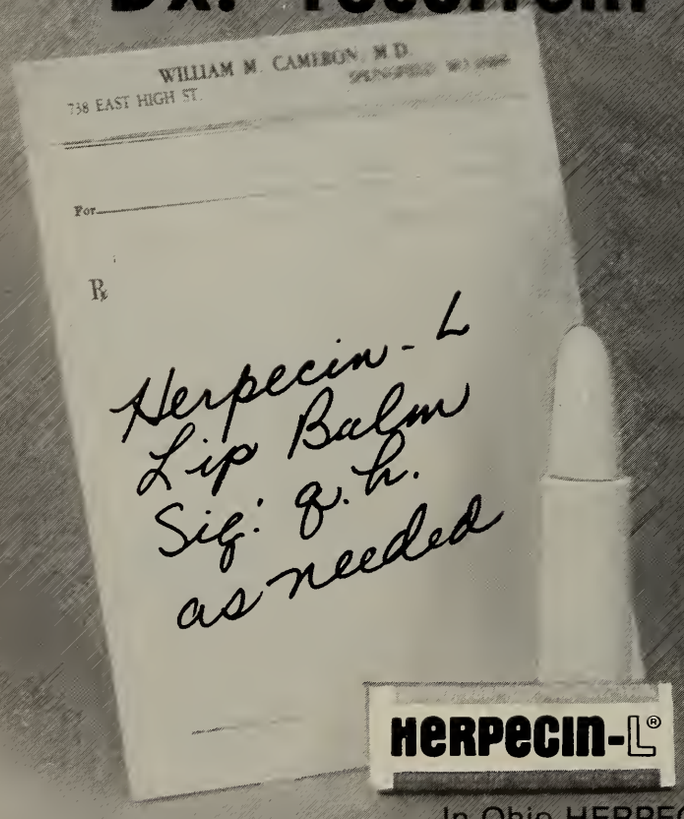
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Have you made your reservations yet for the OMPAC luncheon and "The Spring Fling?" If not, see pages 250 and 251.

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MEDICINE: WHERE DO WE GO FROM HERE?

OSMA Annual Meeting

May 2-7, 1986

Continuing Medical Education Courses

(Received To Date)

ALLERGY AND IMMUNOLOGY

Date: Wednesday, May 7
Place: Room 203, Convention Center
Time: 8:00 a.m. to 12:30 p.m.
Sponsor: Ohio Society of Allergy and Immunology and OSMA Section on Allergy
Topic: Asthma and Allergy: Update 1986
Schedule:
8:00 AM
Introduction
— Barbara A. Pflum, M.D., Dayton, Program Chairman, Ohio Society of Allergy and Immunology
8:10-8:55 AM
Review of Therapeutic Modalities in Asthma
— Charles Reed, M.D., Professor of Medicine, Mayo Medical School, Rochester, Minnesota
9:00-9:45 AM
The Allergist and COPD
— Gary S. Rachelefsky, M.D., Clinical Professor of Pediatrics, University of California, Los Angeles, California
9:50-10:05 AM
Coffee Break
10:10-10:55 AM
Newer Thoughts on IgE Mediated Drug Allergies
— Timothy J. Sullivan, M.D., Associate Professor of Microbiology and Immunology, University of Texas Health Science Center, Dallas, Texas
11:00-11:45 AM
Idiopathic Anaphylaxis
— Roy Patterson, M.D., Professor and Chairman of Medicine, Northwestern University, Chicago, Illinois
11:55 AM-12:10 PM
Panel Discussion
12:30 PM
Luncheon and Business Meeting
Van Cleve III & IV, Stouffer Hotel
Financial support is acknowledged for support of the speakers from: Boehringer-Ingelheim, Ltd.

DERMATOLOGY

Date: Wednesday, May 7
Place: Room 204, Convention Center
Time: 9 AM-12 Noon
Sponsor: Ohio Dermatological Association and the OSMA Section on Dermatology
Schedule:
9-9:30 AM
Diagnostic and Therapeutic Dilemmas of Groin Rashes
— Dwight D. Smith, M.D., Fairborn
9:30-10:15 AM
Practical Approaches to Necrotizing Vasculitis — Diagnosis and Therapy
— Thomas G. Olsen, M.D., Dayton
10:15-10:45 AM
Coffee Break
10:45-11:15 AM
Applications of the CO_2 and argon laser
— Homer E. Williams, M.D., Columbus
11:15 AM-12 Noon
Scabies — Diagnosis and Management
— Stephen Estes, M.D., Wyoming

GERIATRICS/GERONTOLOGY

Date: Monday, May 5
Place: Room 303, Convention Center
Time: 9 AM to 12 Noon
Sponsor: OSMA Section on Geriatrics/Gerontology
Topic: Human Biosenescence and Its Impact on Primary Medical Care
Moderator: Roy L. Donnerberg, M.D., Columbus
Schedule:
9:00-9:45 AM
Keynote Speaker: Ronald D.T. Cape, B.Sc., M.D., F.R.C.P.(E), F.R.C.P.(C), F.A.C.P., Professor, Department of Medicine
Chairman, Division of Geriatric Medicine, Faculty of Medicine, University of Western Ontario, London, Ontario, Canada
9:45-10:00 AM
Clinical Pearls on How To Keep Your Elderly Healthy In the Hospital
Sharon Washington, M.D., Ohio State University College of Medicine, Columbus
10:00-10:30 AM
Coffee Break
10:30-12 Noon
Reactive Panel Participants
Dr. Washington
Dr. Cape
John Newton, M.D., Toledo
Watson Parker, Jr., M.D., Dayton
Kenneth Frederick, M.D., Cincinnati
Mrs. Fifi Pfahl, Huron
Stella Reading, R.N., Columbus
Subjects to be Covered:
- Expanded Roles of the Office Personnel
- Office Rehabilitation of the Elderly
- How Geriatrics Fits Into Primary Care
- Modification of Primary Care Needs

12 Noon
Business Meeting and Election of Officers

NEUROLOGY

CME Hours: 3 Category II
Date: Monday, May 5
Place: Room 302, Convention Center
Time: 8:50 AM-12:30 PM
Sponsor: OSMA Section on Neurology
Program Chairman: Samuel E. Pitner, M.D., Dayton
Schedule:
8:50-9:00 AM
Introduction
— Samuel E. Pitner, M.D., Dayton, Professor and Chairman of Neurology, Wright State University, Dayton
9:00-9:30 AM

What's New in Neonatal Neurology
— Daniel Lacey, M.D., Ph.D., Associate Professor of Neurology and Pediatrics, Wright State University, Dayton
9:30-10:00 AM
Molecular Genetics and Duchenne Muscular Dystrophy
— Jerry R. Mendell, M.D., Professor of Neurology, Ohio State University, Columbus
10:00-10:30 AM
Discussion and Break
10:30-11:00 AM
Dementia and Parkinsonism
— George W. Paulson, M.D., Professor and Chairman of Neurology, Ohio State University, Columbus
11:00-11:30 AM
Gamma Hydroxy Butyrate in the Treatment of Narcolepsy
— Martin Scharf, Ph.D., Associate Professor of Psychiatry, University of Cincinnati, Cincinnati
11:30-11:45 AM
Discussion
11:45 AM-12:30 PM
Case Presentations:
Uncommon Neurological Manifestations of Herpes Varicella Zoster Infections
Thomas Mathews, M.D., Associate Professor of Neurology and Pathology, Wright State University, Dayton
Chief of Neurology, Veterans Administration Medical Center, Dayton
Disulfirium (Antabuse) Neuropathy in a Non-Alcoholic Patient
— Dr. Pitner
Other Presentations to be Announced

NEUROSURGERY

Dates: Monday, May 5 and Tuesday, May 6
Sponsor: Ohio State Neurosurgical Society and OSMA Section on Neurosurgery
Schedule:

Monday, May 5

4-6:30 PM
Annual Business Meeting — Rooms 304-305, Convention Center
7 PM
Cocktails & Dinner
Dayton Racquet Club
29th Floor, Kettering Tower
2nd & Main Streets
Dayton
9 PM
Introduction of Neurosurgeon of the Year, Dr. Martin P. Sayers, Columbus by William Hunt, M.D., Columbus

Tuesday, May 6

Room 203, Convention Center
Mini Symposium on Pediatric Surgery
Moderator: Raymond Sawaya, M.D., Cincinnati
7:30-8 AM
Registration
8-8:05 AM
Introduction — Raymond Sawaya, M.D.
8:05-8:50 AM
Hydromyelia in the Pediatric Population
— John Shillito, Jr., M.D., Honored Guest, Professor of Surgery, Harvard Medical School, Boston, Massachusetts
8:50-9:35 AM
The Incidence and Management of Pediatric Cerebral Spinal Fluid Shunt Infection
— Mark O'Brien, M.D., Atlanta, Georgia
9:35-10 AM
Break (coffee and doughnuts)
10-10:05 AM
Presidential Introduction
— Albert L. Timperman, M.D., Mansfield
10:05-10:50 AM
Experiences with Third Ventriculostomy for Hydrocephalus
— Martin P. Sayers, M.D., Columbus
10:50-11:35 AM
Management of Pediatric Head Injuries
— Kerry Crone, M.D., Cincinnati
11:35 AM-12:20 PM
Predicting Prognosis in Common Pediatric Brain Tumors
— Leland Albright, M.D., Pittsburgh, Pennsylvania
12:20-12:50 PM
Panel Discussion
1 PM
Lunch — Van Cleve IV, Stouffer Hotel, E. Fifth & S. Jefferson Street, Dayton (adjacent to Convention Center via Walkway)

OSMA HOSPITAL MEDICAL STAFF SECTION

Date: Friday, May 2, 1986
Place: Banquet Hall Assembly Main Lobby, Convention Center
Time: 9 AM-12 Noon
Business Meeting:
Opening Remarks
— Herman I. Abromowitz, M.D., Dayton
President, Ohio State Medical Association
The Future of Peer Review
— Dennis O'Leary, M.D., President-Designate, Joint Commission on Accreditation of Hospitals
Dean for Clinical Affairs, George Washington University, Washington, D.C.
Panel Discussion on the Issues Surrounding Peer Review after the Decision in *Patrick v. Burget*
— Thomas Cooney, J.D., Cooney, Crew and Withol, LPA, Portland, Oregon
— Paul R. Frisch, J.D., Staff Counsel, Oregon Medical Association, Portland, Oregon

PATHOLOGY

CME Hours: 6 Category I
Date: Tuesday, May 6
Place: Room 302, Convention Center
Time: 9:00-4:30 PM
Sponsor: Ohio Society of Pathologists and the OSMA Section on Pathology
Program Chairman: John C. Neff, M.D., Columbus
Target Audience: Pathologists, Urologists, Gynecologists
Schedule:
9:00-11:30 AM
Fine Needle Aspiration Biopsy of the Prostate: An Overview
— John A. Maksem, M.D., Division Director of Cytopathology, St. Vincent Charity Hospital, Cleveland
— Paul W. Johenning, M.D., Division of Urology, Department of Surgery, St. Vincent Charity Hospital, Cleveland
11:30 AM-1:00 PM
Luncheon
1:00-4:30 PM
Contemporary Problems in Gynecological Pathology: Selected Case Studies
— Robert Scully, M.D., Department of Pathology, Harvard Medical School, Boston, Massachusetts

PHYSICAL MEDICINE AND REHABILITATION

CME Hours: 3½ Category I
Date: Wednesday, May 7
Place: Van Cleve II, Stouffer Hotel (Luncheon & Dinner)
Room 303, Convention Center (Scientific Program)
Time: 1:30-5:30 PM, Scientific Session
Sponsor: Ohio Society of Physical Medicine and Rehabilitation and the OSMA Section on Physical Medicine and Rehabilitation
Topic: Rehabilitation: State of the Art
Schedule:

12 Noon
Luncheon and Business Meeting — Van Cleve II, Stouffer Hotel
Presiding Officer: Paul F. Gatens, M.D., Columbus
President, Ohio Society of Physical Medicine and Rehabilitation
1:30-1:45 PM
Introduction
— Watson D. Parker, Jr., M.D., Dayton, Program Chairman, Ohio Society of Physical Medicine and Rehabilitation
1:45-3:15 PM
Spinal Cord Injury: Special Problems and Current Developments
1. Respiratory Management and Spinal Cord Injury
A. Evaluation, Management and Follow-up of Quadriplegic Patient
B. Management of the Ventilator Dependent Patient
— Daniel P. Lammertse, M.D., Medical Director, Craig Hospital, Englewood, Colorado
3:15-3:30 PM
Break
3:30-5:30 PM
Advances in Management of Complications of Spinal Cord Injured Patient
A. Pain Management-DREZ Procedure
B. Spasiticy-Neurosurgical Management
C. Post-Traumatic Cystic Myelopathy, Diagnosis and Treatment
— Dr. Lammertse
6:30 PM
Dinner
Van Cleve II, Stouffer Hotel

PLASTIC SURGERY

CME Hours: 2½ Category I
Date: Wednesday, May 7
Place: Room 302, Convention Center
Time: 9:00 AM to 12:00 Noon
Sponsor: OSMA Section on Plastic Surgery
Topic: Basics in Plastic Surgery for General Practice
9:00 AM
Fundamentals in Plastic Surgery
— Robert A. Colgrove, Jr., M.D., Miamisburg
9:20 AM
Common Hand Problems in the Office
— James Apesos, M.D., Dayton
9:40 AM
Evaluation & Treatment of Common Skin Lesions
— Ramchandra Ramnath, M.D., Dayton
10:00 AM
The Use of Tissue Expanders in Plastic Surgery
— Soma S. Avva, M.D., Dayton
10:20 AM
Coffee Break
10:40 AM
Care of Tissue for Reimplantation
— Ravi S. Devara, M.D., Englewood
11:00 AM
Basic Burn Care
— Grace Elias, M.D., Dayton
11:20 AM
Evaluation of Multiple Facial Injuries
— Gloria Thomas, M.D., Dayton
11:40 AM
Care of Pediatric Emergencies
— James Apesos, M.D., Dayton
12:00 Noon
Luncheon
Dayton Room, Stouffer Hotel

PSYCHIATRY

Date: Monday, May 5
Place: Rooms 204 & 303, Convention Center
Luncheon and Business Meeting — Plaza Suite North, Stouffer Hotel
Time: 9:30-11:30 Council Meeting — Room 204, Convention Center
11:30 AM-1:30 PM Luncheon-Business Meeting
1:30-4:30 PM Scientific Session — Room 303, Convention Center
Sponsor: Ohio Psychiatric Association and OSMA Section on Psychiatry
Schedule:
1:30-2:45 PM
The Behavioral Management of AIDS Patients and Their Families
— Jeffery C. Hutzler, M.D., Cleveland
2:45-3:00 PM
Break
3:00-4:15 PM
The Role of the Primary Care Physician in the Treatment of Alcoholism and Other Chemical Dependencies
— Gregory B. Collins, M.D., Cleveland
4:15-4:30 PM
Question and Answer Period

RHEUMATOLOGY

CME Hours: 3 Category I
Date: Monday, May 5
Place: Room 302, Convention Center
Luncheon and Business Meeting — Van Cleve IV, Stouffer Hotel
Time: 11:30 AM-1:00 PM Luncheon-Business Meeting
1:10-4:30 PM Scientific Session
Sponsor: Ohio Society of Rheumatology and the OSMA Section on Rheumatology
Topic: Radiology and Rheumatology: New Approaches in Diagnosis and Assessment
Target Audience: Rheumatologists, Orthopedists and Radiologists
Schedule:
1:10-1:15 PM
Introduction
— Allen M. Segal, D.O., Cleveland, Program Director, Ohio Society of Rheumatology
1:15-2:00 PM
Radiographic Evaluation of Osteoporosis: Update
— Barbara Ann Weissman, M.D., Director of Bone Clinic, Brigham/Women's Hospital, Boston, Massachusetts
Associate Professor of Radiology, Harvard Medical School
2:00-2:45 PM
Smoking and Disc Disease
— Thomas C. Namey, M.D., Associate Professor of Medicine, Chief of Rheumatology, Medical College of Ohio, Toledo
2:45-3:00 PM
Break
3:00-3:45 PM
Radiographic Evaluation and Assessment of Selected Aspects of Rheumatoid Arthritis
— George H. Belhobek, M.D., Chairman, Department of Diagnostic Clinical Radiology
Head, Section of Bone and Joint Disease, Cleveland Clinic Foundation, Cleveland
3:45-4:30 PM
Case Presentations
(Bring interesting or unusual cases and x-rays)

WESTERN OHIO PEDIATRIC SOCIETY

Date: Tuesday, May 6
Place: Dayton Room, Stouffer Hotel
Time: 6:30 PM
Sponsor: Western Ohio Pediatric Society and the Ohio Society of Allergy and Immunology, with financial support from Boehringer-Ingelheim, Ltd.
Schedule:
6:30 PM
Cocktails — courtesy of Ross Laboratories
7:15 PM

Dinner
8:00 PM
Program
"What's New of Kids with Asthma"
— Gary Rachelefsky, M.D., Clinical Professor Pediatrics, UCLA School of Medicine, Los Angeles, California

LOOKING AHEAD: NETWORKING & MENTORING OPPORTUNITIES FOR WOMEN IN MEDICINE

Monday — May 5, 1986
1:00 p.m.- 4:30 p.m.
Room 202, Convention Center

This workshop will look at the changing role of women in medicine. It will specifically focus on constructive networking opportunities, role models and mentors — on-going needs for women physicians and medical students alike. Panelists will provide insights and information on this crucial and timely topic. Workshop attendees will be asked to participate in a solution/strategy session.

Workshop panelists include: Theresa Popp Braun, Office of Student Affairs, Medical College of Ohio at Toledo; Susan J. Clarke, Director of Communications, Academy of Medicine of Cincinnati; Katherine E. Wisse, Associate Executive Director, Ohio State Medical Association; Janice Lloyd, M.D., The Academy of Medicine of Toledo and Lucas County; and Susan Rudd Wynn, M.D., AMA Women in Medicine Project.

Mark your calendar so that you will be able to attend "Looking Ahead: Networking & Mentoring Opportunities for Women in Medicine," held in conjunction with the Ohio State Medical Association 1986 Annual Meeting. This workshop is sponsored by the AMA Women in Medicine Project and the Medical College of Ohio at Toledo in conjunction with the Ohio State Medical Association.

WRIGHT STATE UNIVERSITY SCHOOL OF MEDICINE PROGRAM

CME Hours: 3 Category I
Date: Saturday, May 3
Place: Theater, Convention Center
Time: 1:45 to 4:45 PM
Topic: "Demonstrating Hi-Tech Medicine"
Planning Committee:
John O. Lindower, M.D., Ph.D., Chair
Herman I. Abromowitz, M.D.
Arnold Allen, M.D.
Glenn C. Hamilton, M.D.
Jerry L. Hammon, M.D.
John C. Gillen, M.D.
Donald B. Jentleson, M.P.A.
Alvin E. Rodin, M.D.
Sponsor: Wright State University School of Medicine
Schedule:
1:45 PM
Registration
1:55 PM
Introduction:
— Herman I. Abromowitz, M.D., President of OSMA
Clinical Professor of Family Practice and Community Medicine
Moderator: Discuss/Question after each presentation will be limited by schedule.
— William D. Sawyer, M.D., Dean, Wright State University School of Medicine
Professor of Medicine and Microbiology/Immunology
2:00 PM
Cochlear Implants — A Hearing Marvel
— Robert A. Goldenberg, M.D., Associate Professor and Chair, Department of Otolaryngology, Wright State University School of Medicine
2:40 PM
The Medical Emergency in Flight
— Stanley R. Mohler, M.D., Director of Aerospace Medicine Residency Program
Vice Chair and Professor, Department of Community Medicine
3:20 PM
Break
3:30 PM
Computers and the Paraplegic — A Walking Marvel
— Jerrold S. Petrofsky, Ph.D., Executive Director of WSU National Center for Rehabilitation Engineering
Professor of Biomedical Engineering
4:45 PM
Adjourn
This program is of interest to spouses. Please plan to attend. It demonstrates some marvelous techniques of medicine.

ADVANCED TRAUMA LIFE SUPPORT COURSE

CME Hours: 17 Category I
Dates: Monday, May 5 and Tuesday, May 6
Place: Miami Valley Hospital
Times: Monday, 7:30 AM to 6 PM
Tuesday, 8:00 AM to 6:15 PM
Sponsor: American College of Surgeons and the American College of Emergency Physicians
Fee: $300 pre-registration only
Target Audience: The ATLS Course is specifically designed for the primary care physician, emergency department physician and general surgeon.
Schedule:

Monday, May 5

7:00 AM
Bus leaves East side door of Stouffer Hotel for hospital
7:30 AM-8:00 AM
Continental Breakfast
8:00 AM-8:30 AM
Introduction to ATLS — Course overview
8:30 AM-12 Noon
Lectures: Initial Assessment; Upper Airway Management; Shock; Thoracic Trauma; Abdominal Trauma.
12:00-1:00 PM
Lunch
1:00-5:30 PM
Practical Skill Stations: Surgical Skill Practicum (Cricothyroidotomy; Peritoneal lavage; Pericardiocentesis; Chest Decompression/tube Insertion; Intubation; Anti-Shock Garment Application; IV/Shock Therapy.
6:00 PM
Bus leaves hospital for hotel

Tuesday, May 6

7:00 AM
Bus leaves East side door of Stouffer Hotel for hospital
7:30 AM-8:00 AM
Continental Breakfast
8:00 AM-9:45 AM
Lectures: Head Trauma; Neck/Spinal Trauma; Extremity Trauma; Burns; Stabilization and Transport.
9:45-11:45 AM
Practical Skill Stations:
Mr. Hurt
Extremity Immobilization
Spinal Immobilization
Radiographic Technique
Initial Assessment — practice/test
Case studies
Written Test
11:45 AM-12:15 PM
Lecture
12:15 PM-1:15 PM
Lunch
1:15 PM-2:30 PM
Lectures: Pediatric Trauma; Trauma and Pregnancy; Stabilization and Transportation; Introduction to Initial Assessment.
2:30 PM-5:30 PM
Practical Skill Station
5:30 PM-6:00 PM
Summary and Adjournment
6:15 PM
Bus leaves hospital for hotel

COURSE OBJECTIVES

Upon completion of this ATLS Course, the participant will be able to:

1. Demonstrate concepts and principles of patient assessment
2. Establish management priorities in a trauma situation
3. Initiate primary and secondary management necessary, within the first hour of emergency care for acute life threatening emergencies
4. Demonstrate the skills necessary in initial management of trauma victims:
   - Initial assessment of victims with multiple injuries
   - Application of anti-shock garment
   - Initiation of intravenous therapy with CVP and shock management
   - Adult/infant intubation and nasotracheal intubation
   - Cricothyroidotomy
   - Pleural decompression and chest tube insertion
   - Pericardiocentesis
   - Peritoneal lavage
   - Venous cutdown
   - Extremity and spinal immobilization
   - Head trauma management
5. Demonstrate assessment techniques in the care of traumatized obstetric and pediatric patients.

REGISTRATION FORM
ADVANCED TRAUMA LIFE SUPPORT COURSE
May 5 & 6, 1986

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SPORTS MEDICINE SYMPOSIUM: June 11-13; Sawmill Creek Lodge, Huron; sponsor: The Cleveland Clinic Educational Foundation; 16 credit hours; fee: $200; contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106; phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

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Noted Lecturer, Health Care Economist To Address OMPAC Luncheon

OSMA Annual Meeting — Dayton, Ohio

Saturday, May 3, 1986

Uwe E. Reinhardt, Ph.D., James Madison Professor of Political Economy at Princeton University, will be the featured speaker at the OMPAC luncheon during the 1986 OSMA Annual Meeting in Dayton.



Uwe E. Reinhardt, Ph.D.

As one of the nation's foremost health care economists, Dr. Reinhardt has spoken widely and has been published extensively on the economics of the delivery of health care services.

Dr. Reinhardt is a member of the Advisory Panel on the Regulatory and Competitive Aspects of the Health Care Industry to the US Senate, Associate Editor of the Journal of Health Economics, and is a member of the Department of Health and Human Services Private Sector Task Force on the Pro-Competitive Strategy in Health Care.

The OMPAC luncheon will be held Saturday, May 3, 1986 in the Van Cleve Ballroom of the Stouffer Dayton Plaza Hotel in Dayton. A reception beginning at 11:15 a.m. will precede the noon luncheon.

To make reservations to attend the OMPAC luncheon, please complete the attached form and return it with your check for $20 for each ticket to the Ohio State Medical Association.

Reception: 11:15 a.m. — Luncheon: 12 noon

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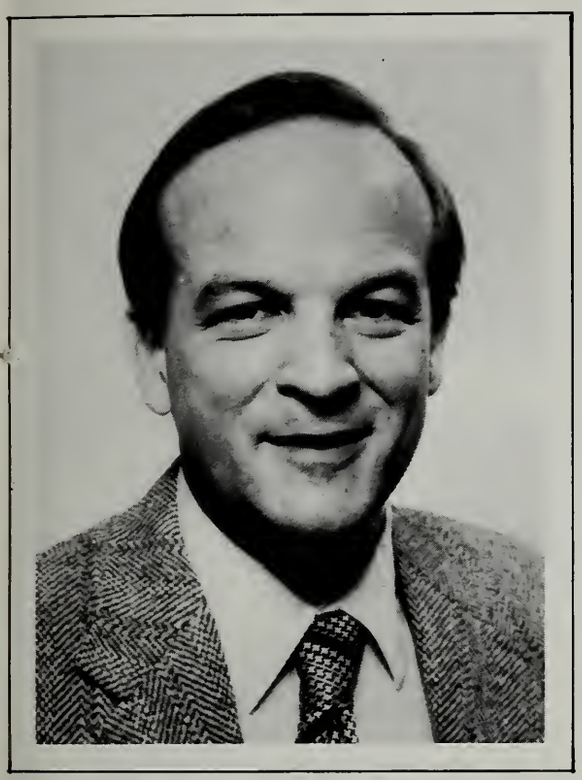
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The Ohio State Medical Association
Hospital Medical Staff Section

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Dennis S. O'Leary, M.D.

President Designate of
The Joint Commission on Accreditation
of Hospitals

"New Issues on Credentialing of Hospital Medical Staff Members and Peer Review"

OSMA-HMSS Annual Meeting

Friday, May 2, 1986 — Dayton Convention Center
Business Meeting—9 a.m. — Presentation—10 a.m.–12 noon

All Physicians Are Invited To Attend

Following Dr. O'Leary's presentation, the OSMA-HMSS will present a panel discussion featuring Paul R. Frisch, J.D., Staff Counsel for the Oregon Medical Association, and Thomas E. Cooney, J.D., of Cooney, Crew and Withol, LPA, Portland, on *Current Issues and Alternatives in Peer Review* with emphasis on the impact of the Federal District Court of Oregon's Decision in *Patrick v. Burget* and other changes in the peer review process. Opening remarks by Herman I. Abromowitz, M.D., President of the Ohio State Medical Association.

A short OSMA-HMSS business meeting, chaired by Edmund W. Jones, M.D., will precede Dr. O'Leary's presentation. Each hospital medical staff is encouraged to send a delegate to represent the hospital in the election of OSMA-HMSS officers.

County Society Officers Executive Directors and Meeting Dates

FIRST DISTRICT

Councilor: *Stanley J. Lucas, M.D.,* 2905 Burnet Ave., Cincinnati 45219.

ADAMS: Jose L. Basa, M.D., President, 17907 State Route 247, Seaman 45679; Juan Young, M.D., Secretary-Treasurer, 829 E. Walnut St., West Union 45693. Second Tuesday quarterly.

BROWN: William H. Bentson, M.D., President, 14 N. Second St., Ripley 45167; Jeffrey S. Donohoo, M.D., Secretary-Treasurer, 111 W. Cherry St., Georgetown 45121. Third Tuesday morning.

***BUTLER:** James P. Baden, M.D., President, 347 Park Ave., Apt. E, Hamilton 45013; Harry M. Davin, M.D., Secretary-Treasurer, 235 Buckeye St., Hamilton 45011; Frances L. Bachman, Executive Secretary, 111 Buckeye St., P.O. Box 3216, Hamilton 45013, 513/893-1410. Third Wednesday except December.

CLERMONT: Bienvenido S. Lee, M.D., President, 9125 Meadow Grove Lane, Cincinnati 45243; William Blake Selnick, D.O., Secretary-Treasurer, Second & E. Loveland Aves., Loveland 45140. Third Wednesday except July and August.

CLINTON: Thomas Neville, M.D., President, 1184 W. Locust St., Wilmington 45177; Bruce Staley, M.D., Secretary-Treasurer, 165 Silver Creek Dr., Wilmington 45177; Marilyn S. Walker, Executive Secretary, 119 Old Rte. 122, Lebanon 45036, 513/382-6611 (lab). Fourth Tuesday.

***HAMILTON:** Lee J. Vesper, M.D., President, 1127 Fehl Lane, Cincinnati 45230; David A. Seltzer, M.D., Secretary, 2123 Auburn Ave., #312, Cincinnati 45219; William J. Galligan, Executive Director, 320 Broadway, Cincinnati 45202, 513/421-7010. Second Tuesday.

HIGHLAND: No active county medical society.

WARREN: Gary Hayes, M.D., President, 1004 Oregonia Rd., Lebanon 45036; Carl Durning, M.D., Secretary, 1618 Deerfield Rd., Lebanon 45036. Second Tuesday.

SECOND DISTRICT

Councilor: *William J. Marshall, M.D.,* 2600 Far Hills Ave., Dayton 45419.

CHAMPAIGN: Ned Saini, M.D., President, 900 Scioto St., Urbana 43078; Jae J. Koh, M.D., Secretary-Treasurer, 27 Rue St. Charles, Urbana 43078. Second Wednesday, February, April, May, then as needed.

CLARK: Carlos Andarsio, M.D., President, 1834 E. High St., Springfield 45505; William A. Garringer, M.D., Secretary, 8490 E. National Rd., South Vienna 45369; Roberta Farish, Executive Secretary, 34 W. High St., Room 710, Springfield 45502, 513/324-8618. Third Monday.

DARKE: Stephen C. Brewer, M.D., President, 552 S. West St., Versailles 45380; Keith Ashbaugh, M.D., Secretary, 7603 Celina Rd., Greenville 45331. Third Tuesday.

GREENE: M. Alam Wirk, M.D., President, Greene Memorial Hospital — Radiology, 1141 N. Monroe Dr., Xenia 45385; Angelo Settembrini, D.O., Secretary, 1099 W. Second St., Xenia 453853713; Judy Khoii, Executive Director, 428 Wilson Dr., Xenia 45385, 513/376-3783. Second Wednesday, March, June, September and December.

***MIAMI:** Peter E. Nims, M.D., President, 20 South Lane, Troy 45373; Donald P. Luna, M.D., Secretary, Piqua Memorial Hospital, 624 Park Ave., Piqua 45356. First Tuesday, September through June.

MONTGOMERY: Blaine L. Block, M.D., President, 2345 Philadelphia Dr., Dayton 45406; David A. Westbrock, M.D., Secretary, 60 Wyoming St., Dayton 45409; Richard G. Tapia, Executive Director, 40 S. Perry St., #100, Dayton 45402,

513/223-0990. Fourth Thursday.

PREBLE: John D. Darrow, M.D., President and Secretary-Treasurer, 228 N. Barron St., Eaton 45320.

SHELBY: Edward A. Link, M.D., President, Third & Michigan Sts., Sidney 45365; Florencio Reyes, M.D., Secretary-Treasurer, 403 Fourth Ave., Sidney 45365. Second Tuesday.

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Councilor: *Thomas R. Leech, M.D.,* 1700 W. Market St., Lima 45805.

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CRAWFORD: G. Wesley Bowersock, M.D., President, 130 Hill St., Bucyrus 44820; Michael A. Johnson, M.D., Secretary-Treasurer, 725 N. Sandusky St., Bucyrus 44820. Meetings when called.

HANCOCK: Jerome F. Beekman, M.D., President, 200 W. Pearl St., Findlay 45840; Richard H. Deerhake, M.D., Secretary, 1818 Chapel Dr., Ste. A, Findlay 45840. Third Tuesday.

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FOURTH DISTRICT

Councilor: *John A. Devany, M.D.,* 2030 Mt. Vernon Blvd., Toledo 43607.

DEFIANCE: Elizabeth M. Gallup, M.D., President, 1400 E. Second St., Defiance 43512; Carl W. Lovell, M.D., Secretary-Treasurer, 313 E. High St., Defiance 435121817. First Saturday.

FULTON: David A. Thompson, M.D., President, 405 E. Lutz Rd., Archbold 43502; Estela T. Miquiabas, M.D., Secretary-Treasurer, 725 S. Shoop Ave.,



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LUCAS: Ernest G. Brookfield, M.D., President, Toledo Hospital, 2142 N. Cove Blvd., Toledo 43606; Richard H. Koop, M.D., Secretary, 4352 Sylvania Ave., Toledo 43623; Lee F. Wealton, Executive Director, 4428 Secor Rd., Toledo 43623, 419/473-3200. Council meets fourth Tuesday except July and August.

OTTAWA: Robert W. Minick, M.D., President, 9849 W. State Route 163, Oak Harbor 43449; Jeffrey F. Wirebaugh, M.D., Secretary-Treasurer, 1122 Lake St., Marblehead 434402034. Second Thursday during football season; otherwise, Friday after second Thursday; no summer meetings.

PAULDING: Kirkwood A. Pritchard, M.D., President and Secretary-Treasurer, 119 S. Main St., Paulding 45879. Third Monday.

PUTNAM: Oliver N. Lugibihl, M.D., President, Box 235, Pandora 45877; Anna M. Horstman, M.D., Secretary-Treasurer, Box 256, Kalida 45853. First Tuesday.

SANDUSKY: J. Kelly Randall, M.D., President and Secretary-Treasurer, 38 Paula Court, Fremont 43420. Third Wednesday.

WILLIAMS: Clarence Bell, Jr., M.D., President, 935 Snyder Ave., Montpelier 43543; Richard L. Hess, M.D., Secretary-Treasurer, 442 W. High St., Bryan 43506. Third Tuesday every other month, September through May.

***WOOD:** Albert W. Smith III, M.D., President, 640 S. Wintergarden Rd., Bowling Green 43402; Robert G. Neville, M.D., Secretary-Treasurer, 960 W. Wooster St., Ste. 207, Bowling Green 43402. Second Tuesday.

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Councilor: *Donavin A. Baumgartner, Jr., M.D.,* St. Luke's Hospital E.R., 11311 Shaker Blvd., Cleveland 44104.

ASHTABULA: Samuel L. Altier, M.D., President, 3509 Carpenter Rd., Ashtabula 44004; Orlando D'Silva, M.D., Secretary-Treasurer, 1111 Lake Ave., Ashtabula 44004; Amy Housel, Executive Secretary, P.O. Box 1772, Ashtabula 44004, 216/998-3111. Second Tuesday.

***CUYAHOGA:** Hermann Menges, Jr., M.D., President, University Sub. Health Ctr., 1611 S. Green Rd., Cleveland 44121; Wilma F. Bergfeld, M.D., Secretary-Treasurer, Cleveland Clinic, 9500 Euclid Ave., Cleveland 44106; George D. Reitz, Executive Director, 11001 Cedar Ave., Cleveland 44106, 216/229-2200. Board of Directors meets second Tuesday.

GEAUGA: Wayne Risius, M.D., President, 13241 Ravenna Rd., Chardon 44024; Mansukhlal Domadia, M.D., Secretary-Treasurer, 14577 E. Park St., Burton 44021; Margaret Pace, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024, 216/286-6131, Ext. 6372. Second Thursday, January, April or May, September and November.

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SIXTH DISTRICT

Councilor: *J. James Anderson, M.D.,* 5204 Mahoning Ave., Ste. 103, Youngstown 44515.

COLUMBIANA: Dardo S. Torti, M.D., President, 2360 Southeast Blvd., Salem 44460; Harry K. Lah, M.D., Secretary-Treasurer, East Liverpool Hospital — Radiology, East Liverpool 43920; Pearl Koenreich, Executive Secretary, 530 Hawley Ave., Salem 44460, 216/337-8859. Third Tuesday, September through May.

MAHONING: Richard A. Memo, M.D., President, 1350 Fifth Ave., Youngstown 44504; Joseph W. Tandatnick, M.D., Secretary, St. Elizabeth Hospital, 1044 Belmont Ave., Youngstown 44501; Robert B. Blake, Executive Director, 1005 Belmont Ave., #245, Youngstown 44504, 216/747-4956. Third Tuesday, January, March, May, September, November and December.

STARK: James Burkholder, M.D., President, 4470 Dressler Rd., N.W., P.O. Box 35006, Canton 44735; Louis A. Kovacs, D.O., Secretary-Treasurer, 3140 Lincoln Way E., Ste. 200, Massillon 44646; Nancy L. Adams, Executive Secretary, 4150 Belden Village St., N.W., Canton 44718, 216/492-3333. Second Thursday, October through April.

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SEVENTH DISTRICT

Councilor: *Nermin D. Lavapies, M.D.,* 1220 Hughes Ave., Martins Ferry 43935.

BELMONT: Chit-Kui Jean, M.D., President, Bellaire Clinic, 3000 Guernsey St., Bellaire 43906; Nermin D. Lavapies, M.D., Secretary-Treasurer, 1220 Hughes Ave., Martins Ferry 43935. Third Thursday, February through April, September through December.

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MONROE: Donald R. Piatt, M.D., President, 154 S. Main St., Woodsfield 43793; Jack M. Matheny II, M.D., Secretary-Treasurer, Monroe County Clinic, Old Airport Rd., Route 3, Woodsfield 43793. Second Wednesday, quarterly.

TUSCARAWAS: Benjamin Wherley, M.D., President, 658 Boulevard, Dover 44622; Leslie S. Harrold, M.D., Secretary-Treasurer, Union Hospital — Pathology, 659 Boulevard, Dover 44622. Second Wednesday.

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FAIRFIELD: Shashi A. Gogate, M.D., President, 6112 Sedgwick Dr., Worthington 43085; John E. Lloyd, M.D., Secretary-Treasurer, 600 Pleasantville Rd., Lancaster 43130; Jane E. Patterson, Executive Secretary, c/o David H. Sheidler, M.D., 1500 E. Main St., Lancaster 43130, 614/654-0059. Second Tuesday.

GUERNSEY: Eshwar B. Punjabi, M.D., President, Medical Arts Bldg., Maple Dr., Cambridge 43725; Janet Brockwell, M.D., Secretary-Treasurer, 65555 Matthews Rd., Rte. 1, Cambridge 43725. First Tuesday every other month beginning in February.

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WASHINGTON: H.L. Krupadev, M.D., President, 400 Matthew St., Marietta 45750; Lloyd D. Dennis, M.D., Secretary-Treasurer, P.O. Box 8, State Route 550, Barlow 45712. Second Wednesday, September through May.

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JACKSON: Louis J. Jindra, M.D., President, P.O. Box 316, Oak Hill 45656; Carl J. Greever, M.D., Secretary-Treasurer, 35 Vaughn St., Jackson 45640.

LAWRENCE: V.S. Kadim, M.D., President, 411 Center St., P.O. Box 883, Ironton 45638; David A. Pack, M.D., Secretary-Treasurer, 1230 Navajo Trail, Ironton 45638. Fourth Thursday.

MEIGS: E.S. Villanueva, M.D., President, 505 Mulberry Heights, Pomeroy 45769; Wilma Mansfield, M.D., Secretary-Treasurer, P.O. Box 351, Pomeroy 45769. Meetings when called.

PIKE: Kenneth A. Wilkinson, M.D., President, 100 Hilltop Rd., Waverly 45690; Shashikant B. Patel, M.D., Secretary-Treasurer, 621 Fifth St., Waverly 45690. Second Monday.

SCIOTO: George Pettit, M.D., President, 3510 Sheridan Rd., Portsmouth 45662; Wayne E. Young, M.D., Secretary-Treasurer, 3146 Fields Court, Portsmouth 45662; Lowell Thompson, Executive Secretary, 1805 27th St., Portsmouth 456622640, 614/354-7581. Second Tuesday, September through June.

VINTON: No active county medical society.

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DELAWARE: Gerald T. French, M.D., President, 1832 Castleton Way, Delaware 43015; Lloyd E. Moore, M.D., Secretary-Treasurer, 141 S. Main St., Prospect 43342. Third Tuesday, March, May, September and December.

FAYETTE: Kevin K. W. Chan, M.D., President, 2 Commercial Ave., Washington C.H. 43160; Robert A. Heiny, M.D., Secretary-Treasurer, 616 Willard St., P.O. Box 457, Washington C.H. 43160. Second Tuesday.

***FRANKLIN:** William Hamelberg, M.D., President, 1492 E. Broad St., Columbus 43205; Phillip D. Jeffers, M.D., Secretary-Treasurer, 3600 Olentangy River Rd., #480, Columbus 43214; James S. Imboden, Executive Director, 525 Metro Place N., Ste. 440, Dublin 43017, 614/766-6221. Meetings in February, August, September and October.

***KNOX:** James J. Wanken, M.D., President, P.O. Box 591, Mt. Vernon 43050; Raymond E. Hatton, M.D., Secretary-Treasurer, 5 N. Gay St., #200, Mt. Vernon 43050. First Wednesday.

MADISON: Martin Markus, M.D., President, 115 E. High St., London 43140; C. Terrill Hay, M.D., Secretary-Treasurer, 214 Elm St., London 43140. Second Wednesday, quarterly.

MORROW: John T. Sweeney, M.D., President, 900 Meadow Lane, Mount Gilead 43338; D. James Hickson, M.D., Secretary-Treasurer, 712 Baker St., Mount Gilead 43338. First Tuesday.

PICKAWAY: Andrew C. Smith, M.D., President, P.O. Box 656, Circleville 43113; Gary L. Gillen, M.D., Secretary-Treasurer, 111 Island Rd., Circleville 43113. Second Tuesday.

ROSS: David Ater, M.D., President, 111 Fruit Hill, Chillicothe 45601; Bruce McNutt, M.D., Secretary-Treasurer, 5 Linwood Dr., Chillicothe 45601. First Thursday.

UNION: Mary T. Coleman, M.D., President, 498 London Ave., Marysville 43040; Jacob Elberfeld, M.D., Secretary-Treasurer, 211 Stocksdale Dr., P.O. Box 328, Marysville 43040. Second Tuesday.

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HOLMES: Maurice E. Mullet, M.D., President, West Main St., Berlin 44610; Daniel J. Miller, M.D., Secretary-Treasurer, Box 143, Walnut Creek 44687. Third Monday.

HURON: Thomas H. Eaton, M.D., President, 813 Northwest St., Bellevue 44811; Pura Garin-Vargas, M.D., Secretary-Treasurer, 38 Executive Dr., Norwalk 44857. Second Wednesday, February, April, June, October and December.

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44035; Romeo S. Miclat, M.D., Secretary-Treasurer, 824 E. Broad St., Elyria 44035; Shirley Dalton, Executive Secretary, 1875 N. Ridge Rd. E., Suite E, Lorain 44055, 216/277-9009. Fourth Monday.

MEDINA: Jeffrey A. Kase, M.D., President, 970 E. Washington St., #304, Medina 44256, Bijay K. Jayaswal, M.D., Secretary-Treasurer, 3647 Medina Rd., Medina 44256; John E. Gerding, Executive Secretary, 3377 Forest Hills Dr., Medina 44256, 216/725-5331. Third Thursday, October through May except December.

RICHLAND: Donald N. Beddard, M.D., President, 480 Glessner Ave., Mansfield 44903; Keith C. Bogart, M.D., Secretary-Treasurer, 222 Marion Ave., Mansfield 44903; Frances V. Cash, Executive Secretary, 295 Glessner Ave., Mansfield 44903, 419/522-4444. Third Thursday.

WAYNE: John W. Thomas, M.D., President, 1749 Cleveland Rd., Wooster 44691; Daniel E. Stump, M.D., Secretary-Treasurer, 1761 Beall Ave., Wooster 44691. Second Wednesday every other month starting with February.

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PORTAGE: Alan Yoho, M.D., President, 6693 N. Chestnut St., Ravenna 44266; Atila N. Can, M.D., Secretary-Treasurer, 152 N. Water St., Kent 44240. Second Tuesday.

SUMMIT: Fred D. Barton, M.D., President, 130 Merz Blvd., Akron 44313; Jack L. Summers, M.D., Secretary, 266 Indian Hills Dr., Tallmadge 44278; Shirley Bee, Managing Director, 430 Grant St., Akron 44311, 216/434-1921. First Tuesday, January, March, May, September and November.



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Generics — Is the Price too High?

By William J. Marshall, MD

Never a week goes by that I am not asked, "Doctor, how do you feel about prescribing generic drugs for me?" This question sets off a series of psychophysiologic reactions within me that have some predictability.

When you consider that over 20,000 of us practice within the state, and knowing my experience is not unique, the question of generic prescribing is common and increasing in frequency. The only reason the patient asks is his concern about costs. He automatically assumes we wouldn't order anything that was less efficacious than a similar brand name product. My problem is will the unbranded product do the same thing in the same timely fashion with identical predictability as the brand pharmaceutical can be counted on to do.

In the field of innovator drugs, research and development is carried out in large part by the pharmaceutical industry. Currently, 70% of the United States research and development is carried out by the industry, 10% by colleges and universities, and the government and other sources make up the remaining 20%. The pharmaceutical industry has allocated over 10% of its expenditures each year for drug research and development, a rate that is secondary only to the information processing and semiconductor industries.

The same cannot be said for the unbranded or generic companies. Their investment in research and development is minimal. They advertise, again, not nearly to the same extent as the brand-name companies. One of the greatest concerns to me is the fact that the generic companies make no attempt to detail the physician about their products. I have not, as yet, been visited and/or detailed by a generic drug house representative at my office or in the hospital.

Congress in 1984, in an effort to improve the payoff of the pharmaceutical companies' major investment and also to provide new incentives for the development of generics, enacted the Competition and Patent Term Restoration Act. Already a number of the larger pharmaceutical houses have begun to develop their own generic lines, and I wouldn't be surprised to see large pharmaceutical companies

"The physician, the only one by law who can prescribe, is faced with the paucity of information."

Generics — Is the Price too High?

continued

buying up smaller generic houses within the next five years.

I make it a point to reserve some time out of each office day to be detailed by a drug company representative. Despite the fact a number of the larger brand-name drug houses now have a generic line, I have yet to be detailed about their generic products without first requesting such information. Even when I pursue the topic aggressively and ask the drug representative directly, I get very little assistance, and almost no information is forthcoming.

All of the above is reminiscent of a silent conspiracy of sorts. The physician, the only one by law who can prescribe, is faced with the paucity of information when asked, "Would you prescribe a generic for me, Doctor?" Absolutely no scientific information comes to us from the generic houses, and the brand name houses avoid detailing us on their generic lines.

The Pharmacy Practice Act has been passed in Ohio which permits pharmacists to utilize generic substitution. This is defined as the act of dispensing a different brand or an unbranded drug product for the drug product prescribed. Theoretically, the substituted drug would be chemically the exact drug entity in the same dosage form but distributed by different companies. There continues to be an unresolved conflict concerning the adequacy of the medical/scientific evidence supporting the notion that drug products, branded or generic, when interchanged will have the same therapeutic result. Efforts to impose "mandatory" rather than "permissive" generic substitution under Medicaid programs appear to be under way in many states. The guidelines for inclusion of a drug in the Ohio Welfare Drug Formulary were revised on March 3, 1983, so no drug could be placed in the formulary if there exists a lower cost drug in the same therapeutic category.*

With permissive substitution being permitted at multiple levels of drug dispensing, problems of clinical inequivalence have already been seen. These problems have been well-documented for a diverse number of drugs, and clinicians have been sensitized to reports about chloramphenicol, digoxin, furosemide, griseofulvin, phenytoin, thioridazine, and tolbutamide. The recognition of these problems has made community pharmacists and the practicing physician aware of other issues such as pharmaceutical alternates and therapeutic inequivalence. Thirty-two separate factors have been identified that can affect the pharmaceutical action of a drug. A pharmaceutical alternate is defined as a drug product which contains the same therapeutic moiety and strength, but differs in the salt, ester or dosage form, and is administered by the same route. A bioinequivalent drug product has been found "generally" equivalent to a standard product in laboratory tests, but performs differently in clinical situations. In truth, the clinical equivalents of pharmaceutical alternates have not yet been assessed. The Federal Drug Administration chose not to evaluate pharmaceutical alternates in its list of therapeutically equivalent drug products, in part due to a paucity of systematic comparisons of alternates on which evaluation could be based.

Before these issues can be resolved and solutions found, another move is afoot across this country to pass legislation that would permit therapeutic substitution. This is defined as the act of dispensing therapeutic alternates for the drug product prescribed. The Iowa legislature passed such a law in 1985 only to have Gov. Terry Branstad veto the bill. The Governor's veto message acknowledged that while the bill was a well-intentioned attempt to reduce the cost of prescription medicine, it would also break new ground regarding the authority of pharmacists in retail practice to therapeutically substitute a different drug than the one actually prescribed by the physician. The Governor felt this latter provision raised public health and liability concerns which have no answer, and on this basis he found it unacceptable. It is anticipated that 12 to 15 states (and rumor has it that Ohio may be one of those) will attempt to pass therapeutic substitution laws in 1985-86. We must do whatever is necessary to educate our legislators, patients and all physicians in this state so that this movement will not get off the ground in Ohio.

Now that Federal law and/or state regulations have permitted substitution when acceptable within the pharmacist's professional judgment, the insurers are getting into the act. On June 1, 1985, Blue Cross and Blue Shield of Northern Ohio

"Sure it's important to save money, but not at the expense of the outcome of the illness."

implemented a generic incentive prescription drug program which is designed to encourage the subscriber (the patient) to accept a generic equivalent drug product by making him pay a co-pay if he insists on the brand-name product and a zero-deductible if a generic equivalent is dispensed. The sad fact is the subscriber enters into this arrangement with insufficient knowledge to make such an important judgment. Unless physicians go to the unions and explain to their leadership and their members what this may mean in the outcome of an illness, they may have many people suffer therapeutic failures and adverse outcomes.

Physicians look at prescribing as one act in a continuum which includes information gathering, assessment, diagnosis and the establishment of therapeutic objectives. It would seem that anything that interferes with the above functions in any of the steps could have an adverse effect on the health of the people of Ohio and indeed the nation.

Those who would like to alter our prescribing methods ask many questions. What judgment algorithm permits a physician to select a therapeutic agent once a pharmaceutical category is determined? Is there a difference in the training of a physician to prescribe generics in place of brand-name products and vice-versa? What are the factors that influence prescribing? How much influence does a detail person have on the physician when he visits in his office? How does the physician weigh cost savings and measure that factor against the desired therapeutic effect?

A solution to the prescribing physicians' dilemma about generic drugs is not available at this moment. Experts in the area feel generic drugs ought to be prescribed on the market only after they have been identified as being therapeutically equivalent to drugs that are already on the market. Probably many of us are at least moderately comfortable with those generics that we don't depend upon to save a life (such as aspirin). My guess is that every physician would second the statement, "When it comes to an important antibiotic; when it comes to medicine for the heart and circulation; when it comes to a drug for cancer chemotherapy, don't give the patients generics unless they have been proven to be the equivalent of the brand-name product." Sure, it's important to save money, but not at the expense of the outcome of the illness.

What can we do? We should write our legislators, federal and state, and inform them of our concern. Each time a drug representative visits our offices, engage him/her in a discussion about generics. They in turn will carry the message back to their pharmaceutical houses. Through organized medicine, let's contact generic houses and promote some much needed dialogue.

In the meantime, I will continue to prescribe predominantly brand-name drugs, a few select generics, and permit no therapeutic substitution. What will you do? Ask yourself the question: Generics — is the price too high?

William J. Marshall, MD, is a Dayton cardiologist and is Second District Councilor of the Ohio State Medical Association.

***Editor's Note:** *The above article originally appeared in the October 1985 issue of* Dayton Medicine. *It was edited and reprinted with permission of the author. The following response to this article appeared in the February 1986 issue of* Dayton Medicine. *It, also, is being reprinted at the request of Dr. Marshall.*

"The guidelines for inclusion of a drug in the Ohio Welfare Drug Formulary were revised on March 3, 1983, so no drug could be placed in the Formulary if there exists a lower cost drug in the same therapeutic category." That March 3, 1983 revision was rescinded almost immediately because many people, including myself, notified the Ohio Department of Public Welfare that the revision was dangerous to the health and welfare of patients.

Shortly thereafter, the Ohio Medicaid Drug Formulary Advisory Group was established to revise the Formulary. I have been the volunteer representing the Ohio State Medical Association in that group for 2½ years. Formulary revisions have been done with much consultation with OSMA members. Many brand name drugs remain in the Formulary, including Chloromycetin, Lanoxin,

"You can do a lot more when you're happy."



Joan Sturgis, Osa Reimann and Frank Sturgis

Osa Reimann
82 years old, Assisted Living resident of Judson Retirement Community

"I was so worried about Aunt Osa," says Joan Sturgis. "We came over together from Denmark in 1937. Life had been good, but before moving to Judson, Aunt Osa was living alone in a big house in Long Island. She could hardly walk, and had few visitors. I'd talk to her every other day and drive up frequently to visit. But life had become a burden. She said she just wanted to die."

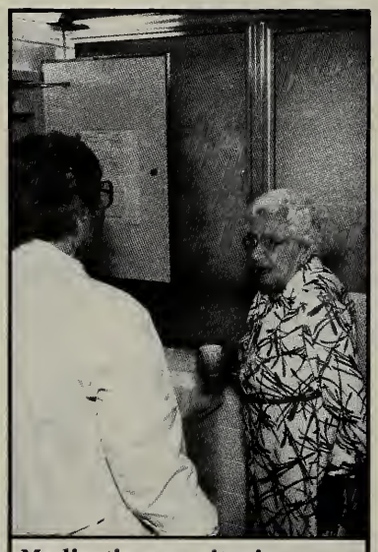
"Now I'm happy," says Aunt Osa. "I can walk much better. I eat well. I don't have to cook or do dishes. I have my own things. Many times when my niece calls me I'm down the hall visiting friends or taking part in an activity. I go to exercise class every day. I do as much as I possibly can."

"Aunt Osa has her own room at our house, too," says Frank. "She stays with us every Sunday and Monday. We have fun together whether we stay home or go out. And, when we take a trip, we don't worry about Aunt Osa. You know, the Danes make the most of each day. And that's what living at Judson is all about."

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Generic drugs . . . *continued*

Lanoxicaps, Lasix, Fulvicin, Dilantin, and Mellaril. Orinase is no longer in the Formulary, but orinase and tolbutamide are seldom used in our Medicaid population because newer oral hypoglycemics are more potent and longer acting. If a brand name drug is not in the Ohio Medicaid Formulary, this means that its generic counterpart can be reasonably expected to be biologically equivalent.

The action a physician must take to insure that his Medicaid and other patients get the brand name drugs he/she prescribes is to write DAW on the prescription. My concern about this is that only about 5% of the prescriptions come to pharmacies with DAW on them. This letter will remind your doctors to write DAW on prescriptions for which they do not want generic substitution. Pharmacists are free to make generic substitution for any prescription, whether for Medicaid or other patients, if the physician does not write DAW on the prescription.

Our committee which is continuing to revise the Ohio Medicaid Drug Formulary is currently unalterably opposed to therapeutic substitution. If Ohio tries to pass therapeutic substitution laws, we will do everything in our power to prevent this. There are no therapeutic substitution bills currently being considered by our Ohio legislature.

I am shocked that Blue Cross and Blue Shield of Northern Ohio have implemented their generic incentive prescription drug program. Northern Ohio physicians should educate their patients and their Blue Cross and Blue Shield about the problems of generic substitution.

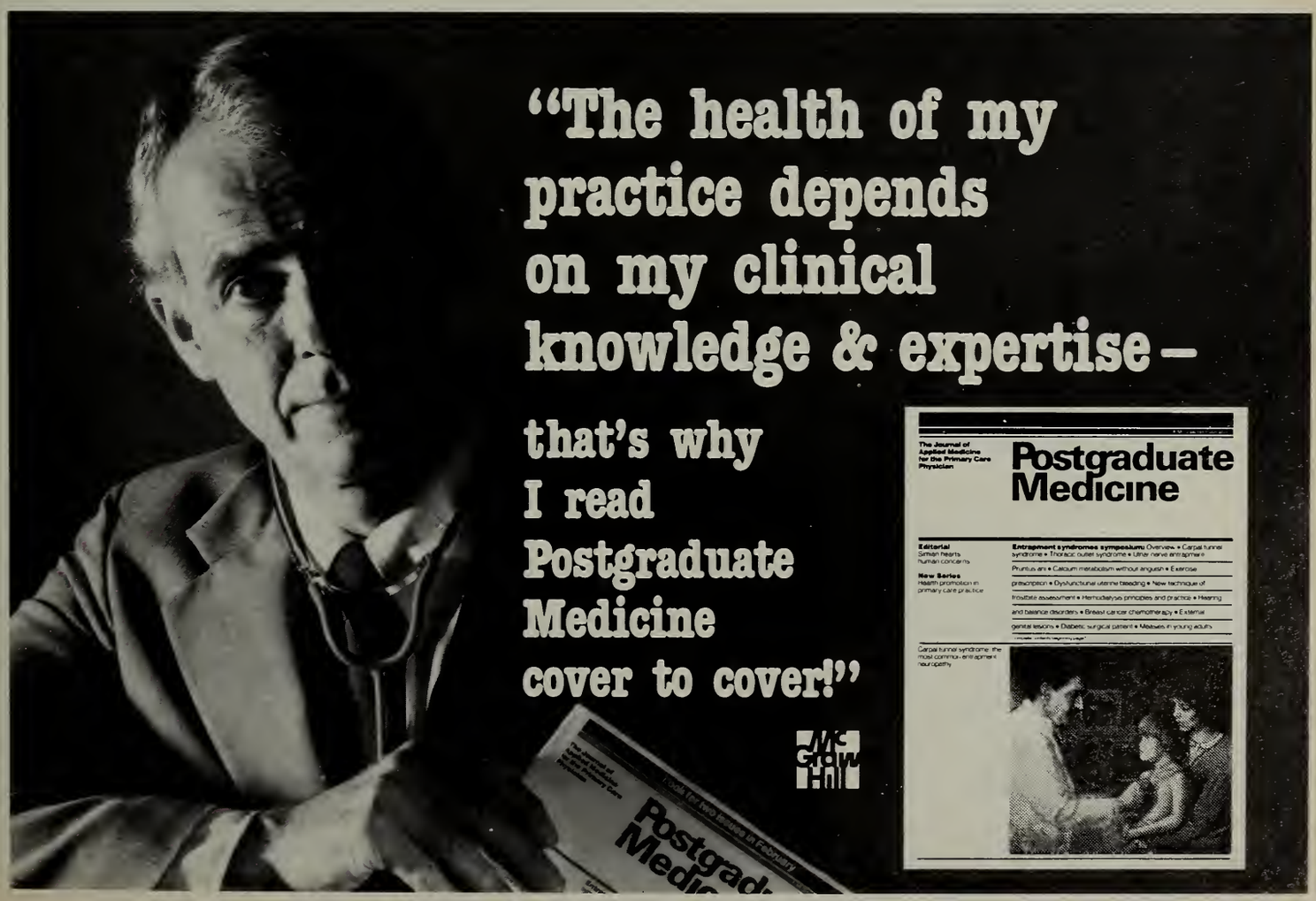
If any of your physicians have problems with Medicaid patients because of the Ohio Medicaid Formulary, please send me the information, so our Formulary Committee can correct the problems.

Thank you for your help.

Sincerely,

Janet K. Bixel, MD

OSMA Representative to Ohio Medicaid Formulary Pharmacy and Therapeutics Committee



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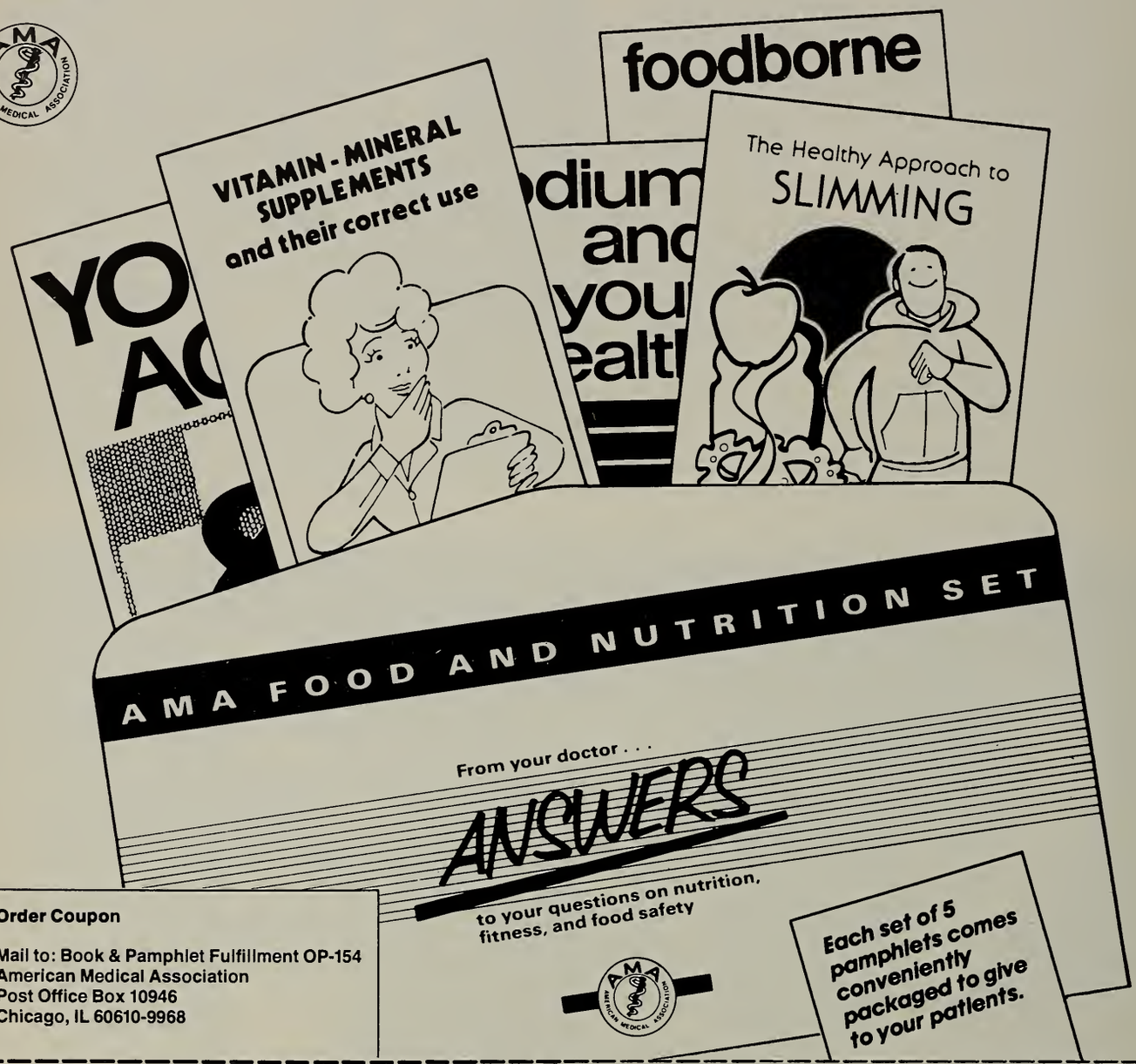
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Physicians Insurance Company of Ohio

By Joseph K. Gilmore

1985 Overview

As PICO entered 1985, rising claims payments and accelerating claim counts over the past several years had created widespread concerns over the medical professional liability insurance industry.

Inconsistencies in trends led to conflicting interpretations by auditors, actuaries and insurers, and caused severe pressure on claims reserve and rate levels.

PICO responded to this serious situation by electing a conservative position. Claims reserves were strengthened to the point that modest operating losses were recorded during the first two quarters of the year. An upward rate adjustment was implemented on August 1.

Initially, this adjustment resulted in rate levels generally higher than those of some other sources of coverage. It is notable that our rates remained competitive with nationally recognized insurers.

During these difficult months, the continued growth of PICO and its subsidiary companies strained internal processing and operations systems. Remedial actions were taken immediately and successfully, to ensure continuation of the high quality of service for which the company has been noted.

Despite these serious challenges, 1985 will be recorded as one of the most successful years in PICO's ten-year history.

During the latter months of the year, other major sources of medical professional liability coverage in Ohio increased rates and/or initiated surplus note requirements to levels which, on an after-tax basis, exceed those of PICO for many risk classifications. Claims statistics through the last half of 1985 supported evidence that some stabilization of claims trends was occurring. The increasingly positive contributions of our subsidiary companies, most notably American Physicians Life Insurance Company and The Professionals Insurance Company, were reflected in the return to profitable operating results during the third and fourth quarters.

The potential impact of health maintenance organizations, preferred provider organizations and independent physician associations on medical professional liability exposure of those entities, as well as on individual physicians, has become a significant factor for consideration and measurement. Appropriately, the PICO board of directors approved the formation of a special ad hoc committee to review and discuss this matter. Recommendations of that committee have been provided to the board and to the Ohio State Medical Association.

Activities of the Loss Awareness Committee have been expanded, commensurate with the increasing need for development and transmittal of vital information to OSMA members by PICO.

PICO is providing all assistance possible to the OSMA Medical Liability Task Force in its effort to consider, develop and recommend appropriate tort reforms to the Ohio Legislature.

Earlier this year, the legislature approved by a wide margin the requirement of an actuarial opinion on rates and reserve levels of medical malpractice insurance companies conducting business in the state. PICO provided assistance to the OSMA in this successful effort to assure physicians in Ohio of this most important attestation to the fiscal

Physicians Insurance Company of Ohio . . . *continued*

strengths of their insurers.

Members of our research and development and corporate planning staffs are completing a very comprehensive review of the rate and reserve levels, historic and current, of major carriers of medical malpractice coverage in Ohio as a basis of maintaining effective measurements of the needs and conditions of the marketplace, and to help ensure that physicians' needs will be met effectively on a long-term basis.

At the conclusion of 1985, PICO's medical professional liability policy count was at a new high; rates were competitive and at appropriate levels; claims reserves remained actuarially adequate and sufficient. An operating profit was recorded for the tenth consecutive year. PICO has successfully weathered a major storm in medical professional liability and maintained the fiscal position of the company, while continuing to meet the needs of the OSMA membership. Perhaps most importantly, we have recognized and initiated appropriate actions to meet new and additional challenges that potentially will have dramatic impact in future years on physicians, and on their professional liability insurers.

Projections for 1986 and beyond

During 1986, it is PICO's intention to introduce a single limit policy for the OSMA Group Plan, which will provide members with a selection of coverage packages. This simplified concept will significantly improve our service capabilities, and help ensure each policyholder of the desired and appropriate coverage limit.

We fully anticipate that our emphasis on appropriate rate and reserve levels will result in an unqualified ("clean") opinion from our auditors, thus ensuring that PICO will continue to be recognized as an insurer deeply committed to the long-term protection of its policyholders.

Because of the extreme pressure being placed on all liability insurers, stemming principally from the reinsurance industry, it is inevitable that PICO and the OSMA will be required to carefully consider our position on the claims-made policy form. Adverse experience in many forms of liability insurance other than medical professional liability, most notably produce and business liability, has created widespread support of the claims-made concept. We are completely committed to protecting our policyholders from the long tail that is most dramatic in medical professional liability. It is our task to adopt innovative concepts that will fuse that commitment with the realities of the reinsurance market.

The hard decisions made by PICO during the past two years with regard to rate adjustments will enable us to avoid the "catch up" rate increases that appear necessary for other carriers. Any adjustment needed in 1986 should be of a more modest nature, and would thus further emphasize the company's appropriate position on rate and reserve levels.

The successful operation of our subsidiary companies, coupled with the maintenance of appropriate rate levels, has eased the pressure on profitability that impacted consolidated operating results during the first half of 1985. An acceptable level of profitability is expected during 1986.

We anticipate that the Ohio Department of Insurance will continue its close watch on Ohio's medical professional liability insurers and we are confident that PICO will withstand the closest and most conservative scrutiny. The bank of statistical data we have compiled on other insurers in our operating area evidence the superior strength of our company. It is probable that subtle pressures will be applied to insurers to improve their fiscal positions through continuation of rate adjustments and/or surplus improvement programs.

PICO will provide all support possible to the OSMA in its effort to obtain appropriate tort reforms on realistic statutes of limitation, capping of awards, reduction of plaintiff legal costs, and similar subjects.

A major activity scheduled for 1986 will be an extensive updating, expansion and revision of our very successful Loss Awareness Program. While continuing to provide detailed information concerning PICO's claims activity, the revised program will also feature vital information on the risk exposure for physicians currently and in the future.

PICO will maintain its well-established reputation for the highest quality of service, through the product packaging concept

indicated above, improved and simplified billing systems, and increased emphasis on customer service communications. We accept the challenge of providing more sophisticated, yet simplified, methods of serving our policyholders during a period of rapid changes in the traditional organizational concepts of medical practice. **OSMA**

Joseph K. Gilmore is President of PICO.

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THE Ohio STATE Medical Journal

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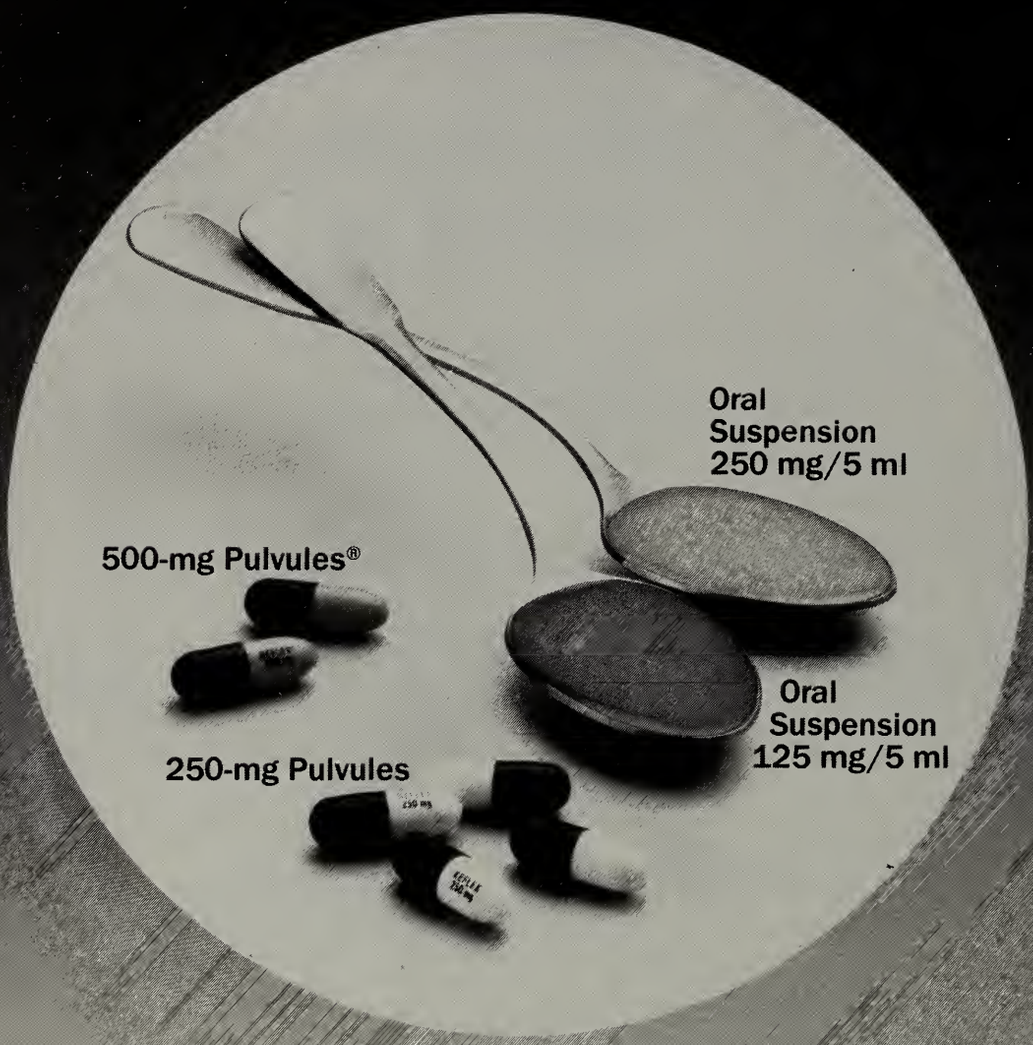
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Ophthalmologists provide eye care for elderly in nationwide project

By Doug Evans

A special nationwide project that will provide professional medical and surgical eye care to the elderly, regardless of their ability to pay, will begin May 5 in Ohio.

The program, called the National Eye Care Project (NECP), is sponsored by the Foundation of the American Academy of Ophthalmology and the Ohio Ophthalmological Society. It is designed to make available professional medical eye care to the needy elderly with no out-of-pocket expense to the patient.

"It is estimated that over one million Americans over age 65 do not have Medicare or any other health insurance coverage, and that is precisely the age group which is the most vulnerable to potentially blinding eye disease," said Bruce R. Paxton, MD, president of the Ohio Ophthalmological Society and statewide implementation chairman for the NECP. "It is our goal that through this program we will ensure that every older American will receive the medical eye care he or she needs, regardless of their ability to pay for that care.

"Simply stated, we do not feel that an individual should have to take the risk of going blind due to their inability to pay for an examination," according to Dr. Paxton.

Dr. Paxton said that every patient participating in the program will be given a comprehensive eye examination and a determination will be made of the further care needed to preserve the patient's vision.

Ophthalmologists who have volunteered to participate in the program have agreed to accept Medicare and insurance assignment as payment for services in full. In those cases when a patient is not covered by any insurance, the ophthalmologist's services will be provided free of charge.

It is estimated that the project will cost more than $3 million to operate in 1986.

"The funds to operate this program are coming entirely from the private sector, with about half coming from voluntary contributions from ophthalmologists," said Paxton. "In Ohio, thanks to the efforts of Abbot Spaulding, MD, from Cincinnati, and Lawrence Singerman, MD, from Cleveland, who are heading the fund-raising effort, we have surpassed our fund-raising goal."

Below are additional facts regarding the National Eye Care Project.

Q. How will patients find out about the National Eye Care Project?

A. An intensive media campaign will precede the opening of the NECP in each area of the country. Television public service announcements featuring John Forsythe, Mary Martin and Gene Kelly will highlight medical eye care and list the Helpline telephone number established to direct inquiries. Cary Grant will be heard in radio announcements. Every daily and weekly newspaper, plus magazines and publications for the elderly, will receive news releases from the Academy.

Q. How will patients be referred to participating physicians?

A. When a patient calls the toll-free NECP Helpline, he or she will be assigned by computer to a volunteer physician as close as possible to the patient's home. Assignments will be in rotating order; a physician will receive a second patient only after all other volunteer ophthalmologists in the area have been assigned a first patient.

Q. Does that mean that every patient referred will call an ophthalmologist's office?

A. Probably not. It is up to the patient to call for an appointment after receiving the referral. However, because these patients are motivated to call and seek care, it is likely that a high percentage will make and keep office appointments.

Q. Will all of these be non-paying "needy" patients?

A. No. More than 90 percent are likely to be covered by Medicare Part B or some other form of health insurance, according to a three-state NECP pilot project. From five to nine percent will be genuinely needy, with no way to pay for their care.

Q. What services are involved in the program?

A. In accepting a patient, the volunteer physician agrees to provide treatment for as long as necessary for the condition(s) diagnosed. Patients are informed in their referral letter that this is not an eye glasses program.

Q. What if the needy patient requires surgery or other hospital care?

A. The volunteer ophthalmologists are asked to work with their local hospital to make this care available, just as they would with other needy patients. Some hospitals have accepted an obligation under the Hill-Burton Act and other programs to provide a certain amount of free care. Today, hospitals are under increasing financial pressures, but almost all recognized the responsibility to care for needy patients such as these.

Q. How many patients can an ophthalmologist expect?

A. This depends on (1) the number of patients in the area who call the NCEP Helpline, (2) the number of ophthalmologists in the area who volunteer to participate, and (3) the number of patients who make and keep appointments. Up to 200,000 calls, resulting in 125,000 referrals, are anticipated in the first year of operation. Because of the variance in these three factors, all ophthalmologists will not receive the same number of patients.

Q. How many physicians across the country will be involved?

A. Nearly 8,000 Academy members across the country have volunteered.

Doug Evans is the Assistant Director of OSMA's Department of Communications.

Colleagues In The News

Edited by Deborah Athy

GEORGE A. NANKERVIS, PhD, MD, has been named chairman of the Department of Pediatrics at Children's Hospital Medical Center of Akron.

RAFAEL L. PEREZ, MD, Dayton, has received the Wright State Academy of Medicine's Outstanding Resident Award.

LEONARD PERSKY, MD, of Mt. Sinai Hospital in Cleveland, received a Special Distinguished Service Award from the American Urology Association for recognition in his field.

DWIGHT D. SMITH, MD, Dayton, has been appointed acting chair of the Department of Dermatology at Wright State University School of Medicine.

LOUIS FINKELMEIER, MD, Celina, has been appointed health commissioner of Mercer County by the county board of health. Dr. Finkelmeier has been a member of the board of health since September 1983.

STANLEY R. MOHLER, MD, Dayton, has received the Lawrence P. Sharples Award for outstanding contributions to the field of aviation from the Aircraft Owners and Pilots Association.

MAVIS FUJII, MD, Dayton, has received an Amelia Earhart Fellowship from Zonta International, a worldwide service organization of executive women in business and the professions. Dr. Fujii is the first physician to receive the fellowship.

LESLIE LAUFMAN, MD, Columbus, has been elected to a three-year term on the board of directors of the Columbus Cancer Clinic.

ORLANDO J. MARTELO, MD, Cincinnati, has been awarded the title of American Cancer Society Professor of Clinical Oncology. The award is presented every five years to four professors of oncology in Ohio.

GEORGE A. ROURKE, MD, Lebanon, has been elected to the Warren County Board of Health.

WILLIAM A. SPOHN, MD, Dayton, has been elected to the board of directors of the Cystic Fibrosis Foundation, Central Ohio Chapter. Dr. Spohn will be serving on the chapter's Public Policy Committee.

Patient's Informed Consent

By Douglas Graff, J.D.; Catherine Costello, J.D.; and D. Brent Mulgrew, J.D.

The concept of informed consent has its roots in both the patient's right of privacy and the nature of the physician-patient relationship. A physician is in a fiduciary relationship with his or her patients and owes a duty of good faith and fair dealing to the patient. The physician must exercise both due care and skill, and fully disclose to the patient the facts and circumstances of that patient's condition.

In the absence of an emergency that would necessitate immediate medical care, a physician must obtain the consent of the patient prior to the medical or surgical procedure to be performed. A physician who treats a patient without obtaining consent may be guilty of a battery, even though the treatment or procedure is beneficial or harmless.

Not only must a patient grant his or her consent to the procedure, but the patient's consent must be an "informed consent." A patient may bring an action for the tort of lack of informed consent or for battery if the patient's consent is given without sufficient knowledge and understanding of the nature of the procedure.

A. The Tort of Lack of Informed Consent

In *Nickell* v. *Gonzalez,* 17 Ohio St. 3d 136, (1985), the Ohio Supreme Court reviewed the statutory and common law necessity that physicians disclose the material risks and dangers inherently and potentially involved with respect to a proposed treatment or procedure.

Dr. Gonzalez performed a thoracic outlet syndrome operation on the plaintiff, Donna Nickell. Subsequently, the plaintiff experienced brachial plexus palsy, paralysis of the nerves in the neck and armpit, extending to the entire arm. Nickell sued Dr. Gonzalez for failing to adequately disclose the risk of paralysis from the surgery. Dr. Gonzalez had not informed the plaintiff that there was a risk of paralysis.

The Ohio Supreme Court held that a standard of reasonableness was necessary to determine which risks are material and must be disclosed to a patient. The Court cited with approval the trial court's jury instruction that:

> *". . . a risk is material when a reasonable person, in what the physician knows or should know to be the patient's condition, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed treatment."*

While the Ohio Supreme Court did not find the physician liable in this case, the Court held that the tort of lack of informed consent was recognized in Ohio. The Court found that the tort of lack of informed consent is established when:

"(a) The physician fails to disclose to the patient and discuss the material risks and dangers inherently and potentially involved with respect to the proposed therapy, if any;

(b) the unrevealed risks and dangers which should have been disclosed by the physician actually materialize and are the proximate cause of the injury to the patient; and

(c) a reasonable person in the position of the patient would have decided against the therapy had the material risks and dangers inherent and incidental to treatment been disclosed to him or her prior to the therapy."

The Supreme Court reviewed the evidence and concluded that the jury verdict in favor of the physician should be upheld. The court found that the testimony at trial had indicated that brachial plexus palsy was not considered to be a normal danger of the operation, and that there was a question whether the operation had caused the patient's condition. Moreover, because reasonable minds could differ as to whether disclosure of the extraordinary and improbable risk of brachial plexus palsy would have dissuaded a reasonable patient from undergoing the "routine"

Patient's Informed Consent

continued

operation, the jury verdict must be reinstated for the physician.

B. **Ohio's Informed Consent Statute**

Physicians may be able to protect themselves from an action by a patient for battery or lack of informed consent in connection with a surgical or medical procedure if a written consent form, conforming to the requirements of Ohio law, has been signed by a patient or the patient's legal representative.

A written consent form, to be within the "safe harbor" protection must meet the requirements of Ohio Revised Code Section 2317.54, which are as follows:

"(A) The consent sets forth in general terms the nature and purpose of the procedure or procedures, and what the procedures are expected to accomplish, together with the reasonably known risks, and, except in emergency situations sets forth the names of the physicians who shall perform the intended surgical procedures.

(B) The person making the consent acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.

(C) The consent is signed by the patient for whom the procedure is to be performed, or, if the patient for any reason including, but not limited to, competence, infancy, or the fact that, at the latest time that the consent is needed, the patient is under the influence of alcohol, hallucinogens, or drugs, lacks legal capacity to consent, by a person who has legal authority to consent on behalf of such patient in such circumstances."

If these three requirements have been satisfied, the written consent will be presumed to be valid and effective unless the consent was obtained from an individual who was not acting in good faith, or the consent was induced by fraudulent misrepresentation of material facts (see previous discussion of "material" facts), or the person who consented could not effectively communicate in English, or the language in which the form is written. In all civil and criminal trials, no evidence will be admissible to "impeach, modify or limit the authorization for performance of the procedure or procedures set forth in such written consent."

Section 2317.54 ORC does not change the other permissible forms of granting consent by a patient. Oral consent to treatment and implied consent continues to be available alternatives. The law has recognized that there are situations where the consent of a patient will be implied or presumed when the circumstances render the patient's consent impossible or impractical to obtain. First, where a patient is not competent to consent, an individual who is legally authorized may consent to treatment on the patient's behalf. For example, parents and guardians can consent to treatment for minor children or for their wards. Second, a patient's consent may be implied under certain conditions. However, the facts and circumstances must be more than the mere inability of the patient to consent. Life or limb threatening injuries are often circumstances that provide for implied consent to medical treatment.

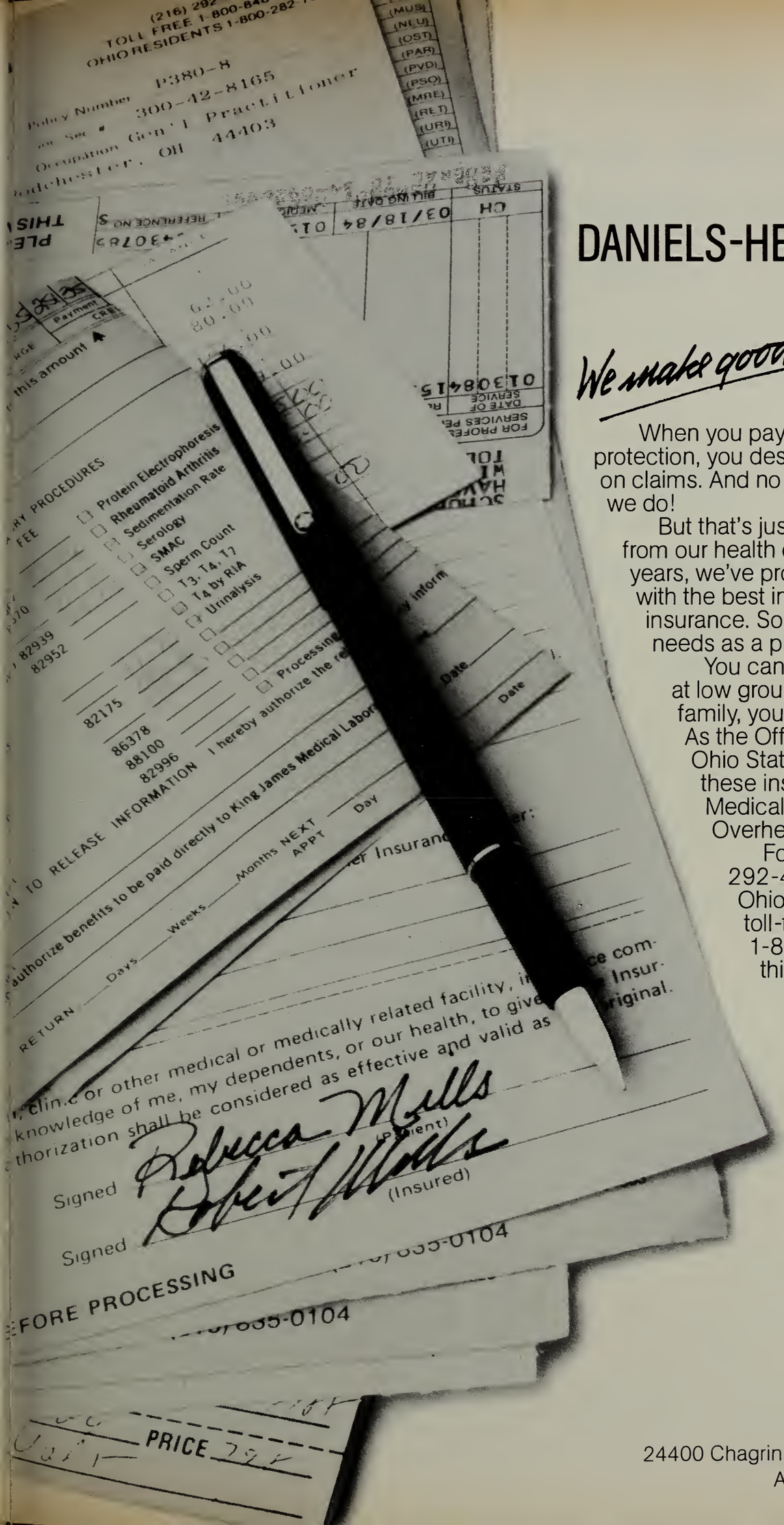
The law will recognize that express consent to treatment of a specified condition through a surgical procedure may imply consent to all other necessary procedures which become necessary for the achievement of the intended result. However, the implied consent will not necessarily include procedures that were not contemplated within the original consent.

Conclusions

All physicians should develop written consent forms for use in their practices which conform with the provisions of Ohio Revised Code Section 2317.54. Patients should be encouraged to ask questions of the physician concerning all material risks of a proposed treatment or procedure.

Ohio case law recognizes that some risks are so remote and unusual that they are not material and need not be disclosed. However, physicians should discuss thoroughly the known material risks and their effects with all patients, and obtain a written consent to treatment.

Catherine Costello and Douglas Graff are with the OSMA's Department of Legal Affairs. D. Brent Mulgrew is Managing Director, OSMA.



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RESULTS OF OHIO'S PHYSICIAN OUTREACH PROGRAM 1985 HOUSE OF DELEGATES

Program Results

Participants:	**111 Delegates or Alternates**
Names Selected:	**606 Nonmembers**
Response Cards:	**288 Cards returned**
Successful Recruiters:	**37 Delegates or Alternates**

Award Winners

FIRST PLACE: 22 new members
William T. Paul, MD
Academy of Medicine of Columbus & Franklin County

SECOND PLACE: 11 new members
Donavin A. Baumgartner, Jr., MD
Academy of Medicine of Cleveland

THIRD PLACE: 3 new members
Janet K. Bixel, MD
Academy of Columbus & Franklin County

Thomas E. Gretter, MD
Academy of Medicine of Cleveland

James A. Murray, MD
Seneca County Medical Society

Robert M. Zollinger, MD
Academy of Medicine of Cleveland

Other Recruiters and County of Membership:

2 New Members

Ronald B. Berggren, MD — Franklin
J. Richard Briggs, MD — Franklin
Stephen C. Kim, MD — Crawford
Nermin D. Lavapies, MD — Belmont
Howard W. Lowery, MD — Franklin
Walter E. Matern, MD — Hamilton
S. Baird Pfahl, MD — Erie
Daniel E. Santos, MD — Hamilton
O. David Solomon, MD — Cuyahoga
Claire V. Wolfe, MD — Franklin
Gene E. Wright, MD — Allen

All award winners will be recognized at the 1986 Annual Meeting. Counties with 100% membership will also be recognized. They are:

- **Fayette**
- **Geauga**
- **Hardin**
- **Madison**
- **Morrow**
- **Ottawa**
- **Perry**
- **Shelby**

Claire V. Wolfe, MD, also was one of the 27 physicians who received a Physician Outreach tie at the AMA Interim Meeting in Washington for her successful recruitment of AMA winners.

1 New Member

Paul E. Andorfer, MD — Clark
J. James Anderson, MD — Mahoning
Richard W. Avery, MD — Medina
Sabino T. Baluyot, MD — Hamilton
William S. Banfield, MD — Franklin
Theodore J. Castele, MD — Cuyahoga
George E. Ewing, MD — Summit
Roland A. Gandy, MD — Lucas
Edmond W. Gardner, MD — Franklin
John J. Gaughan, MD — Cuyahoga
William H. Gates, MD — Hamilton
Ray W. Gifford, MD — Cuyahoga
Donald A. Hammel, MD — Portage
John A. Hasley, MD — Lucas
William F. Hughes, MD — Franklin
Owen E. Johnson, MD — Franklin
Bernard M. Kuhr, MD — Franklin
Richard J. Nowak, MD — Cuyahoga
John W. Ray, MD — Muskingum
Peggy Jeanne St. Clair, MD — Cuyahoga

Editor's note: *This month, the Journal begins a series of articles on membership.*

Membership is the Name of the Game

By Thomas W. Morgan, MD

Ohio's Physician Outreach Program, an ambitious project to increase OSMA membership, was launched at last year's Annual Meeting. After being apprised of the ominous national downward trend in medical society membership, members of the House of Delegates were asked to participate in the peer-to-peer recruitment project to attract new members.

111 OSMA delegates and alternates agreed to contact five nonmembers each, resulting in the contact of 606 prospects. From this group of prospective members, 288 response cards were returned. Ultimately 87 new members were acquired through this effort. Thirty-three percent of the delegates/alternates were successful in recruiting new members.

At first glance this may appear a small return for such a large effort, but these new members accounted for nearly $11,000 in new dues income based on one-half year dues for the first year. Next year at full rates, this amount would double. It is clear that one of the most important immediate financial benefits of increased membership might well be that a dues increase could become unnecessary. Medical societies make every effort to avoid dues increases.

It has been conservatively estimated that the total amount of state medical society dues necessary to produce enough revenue to fund society services could have been reduced by at least 25% if all active practicing physicians in the state were members. It is sobering to reflect that your dues not only could have been 25% less but that you have actually been subsidizing Ohio "free riders" who share most of the same benefits you do by at least $100.00 per physician member per year! This statistic alone emphasizes the overwhelming economic basis for making medical society membership attractive and necessary.

AMA membership was also promoted during this project and the resulting modest increase in AMA members helped to qualify the OSMA for additional representation in the AMA House of Delegates.

Of the many reasons why membership must be increased, none is more compelling than the reduced percentage of members among younger physicians. Membership among physicians under age 40 has dropped nationally to 34% compared to 52% for those between the ages of 40 and 65. Older physicians have traditionally been faithful medical society members. If this trend is not reversed, overall medical society membership will surely fall dangerously below 50% by the year 2000.

For this reason alone our recent strong efforts to enroll medical students and residents have been assigned the highest priority. Student membership has risen from only *13* in 1980 to *3,100* in 1985. Residents have gone from *187* to *2,495* in the same period.

The Committee on Membership is pleased to report the following historical informational data: OSMA membership has almost doubled in the past ten years — from 10,867 in 1975 to 19,179 in 1985. This growth was accelerated in the last five years, 1981 to 1985, with the offer of free membership to students and residents. However, it should be

noted that while total membership has experienced a 45% growth over the past five years, the *number of active full dues paying members has grown only slightly.*

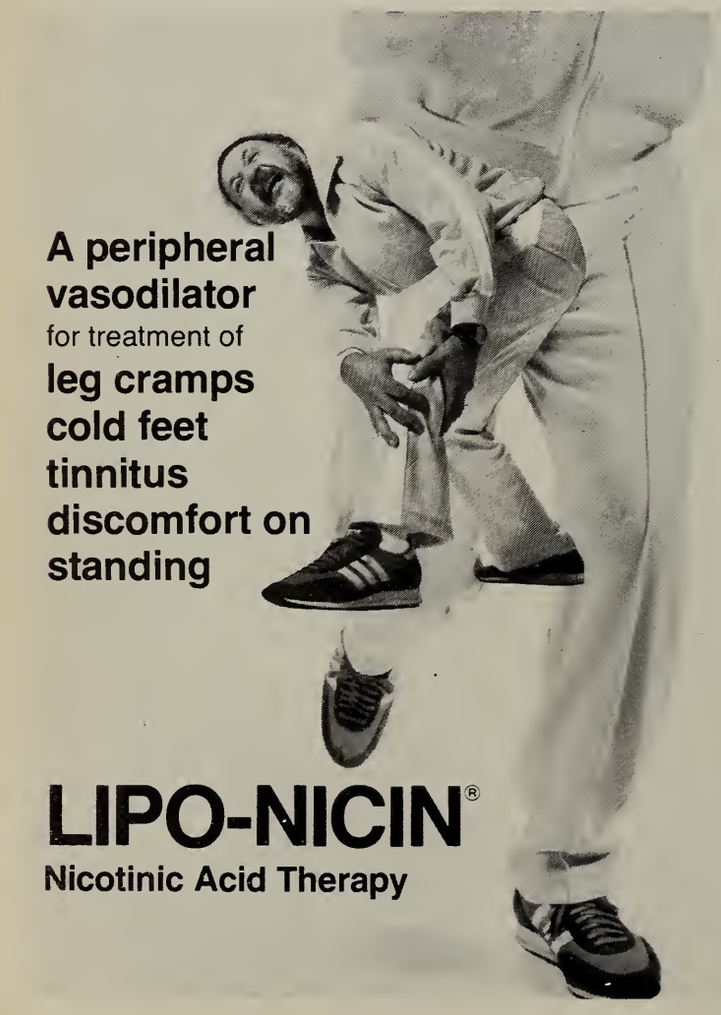
OSMA dues represented 77.5% of total revenue in 1985. Despite a modest decline in full dues paying members, 1985 dues revenue grew from $2,259,825 to $2,987,582 because of the $55.00 dues increase and last year's peer-to-peer recruitment program.

OSMA enjoyed 83.8% of the practicing physician market in 1975 when the total number of practicing physicians in Ohio was 12,875. In 1983, the total was 16,684 with OSMA's membership market share at 77.8%. OSMA has actively engaged in membership recruitment for the past eight years. Prior to that, recruitment was the sole responsibility of the county society. Cooperation and interface with the county societies is inherent in all OSMA membership recruitment efforts. AMA's membership in Ohio has also grown from 8,214 in 1975 to 15,693 in 1985. AMA's percentage of OSMA members has remained close to 76% over the years compared to an AMA membership average of 45% nationwide.

OSMA is proud of its membership achievements. Increased OSMA and AMA membership is our challenge for 1986 and 1987. The upward trend of membership that has already been realized must be continued through aggressive and innovative membership recruitment and retention programs.

The need for new members both for immediate financial considerations and also for the future survival of organized medicine is abundantly clear to the Committee on Membership. So for this reason, the committee is organizing another peer-to-peer recruitment program for the House of Delegates at the 1986 Annual Meeting. With a total membership potential in Ohio of 24,800 (including students and residents), compared to OSMA membership of 19,000+, approximately 6000 nonmember physicians remain as a target for membership recruitment. We trust that Delegates and Alternates will rise to the challenge at the Alumni Meeting in May. **OSMA**

Thomas W. Morgan, MD, is Chairman of the OSMA Committee on Membership.



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Pyridoxine HCL (B-6) .....10 mg.
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CHARLES H. BROWN, MD,
Chesterland; Rush Medical College, Chicago, Illinois, 1938; age 72; died January 4, 1986; member OSMA and AMA.

A.R. CALLANDER, MD,
Delaware; Rush Medical College, Chicago, Illinois, 1926; age 87; died January 13, 1986; member OSMA and AMA.

OSCAR CODDINGTON, MD,
Deland, Florida; Ohio State University College of Medicine, 1926; age 85; died January 23, 1986; member OSMA and AMA.

VASILE G. COSERIU, MD,
Cleveland; Institutul de Medicina si Farmacie Clui, Romania, 1946; age 65, died January 28, 1986; member OSMA and AMA.

JAMES A. DANFORD, MD,
Piqua; George Washington University School of Medicine, Washington, D.C., 1954; age 57; died January 14, 1986; member OSMA and AMA.

JAMES I. KENDRICK, MD,
Cleveland; University of Texas Medical Branch, Galveston, Texas, 1931; age 79; died January 16, 1986; member OSMA and AMA.

JOHN S. MACKRELL, MD,
Cleveland; University of Pittsburgh School of Medicine, 1939; age 71; died January 19, 1986; member OSMA and AMA.

JOSEPH J. MAJOR, MD,
Cleveland; Institutul de Medicina si Farmacie Clui, Romania, 1933; age 79; died January 8, 1986; member OSMA and AMA.

CHARLES V. MOOERS, MD,
Columbus; University of Michigan Medical School, Ann Arbor, Michigan, 1956; age 55; died January 29, 1986; member OSMA and AMA.

GEORGE I. NELSON, MD,
Dublin; University of Iowa College of Medicine, Iowa City, Iowa, 1923; age 90; died January 30, 1986; member OSMA and AMA.

GORDON G. NELSON, MD,
Youngstown; University of Minnesota Medical School, Minneapolis, Minnesota, 1927; age 85; died January 10, 1986; member OSMA and AMA.

FREDERICK H. SHILLITO, MD,
Columbus; Harvard Medical School, Boston, Massachusetts, 1931; age 80; died December 26, 1986; member OSMA and AMA.

LEOPOLD W. SIBERD, MD,
Toledo; Ohio State University College of Medicine, 1946; age 72; died January 18, 1986; member OSMA and AMA.

EDWARD C. SVEC, MD,
Cleveland; Case Western Reserve University School of Medicine, 1944; age 66; died January 6, 1986; member OSMA and AMA.

ROBERT C. TARAZI, MD,
Cleveland; Kasr El Aini Faculty of Medicine, Cairo, Egypt, 1949; age 60; died January 21, 1986; member OSMA and AMA.

ERNEST H. WINTERHOFF, MD,
Mechanicsburg; Ohio State University College of Medicine, 1945; age 65; died December 27, 1985; member OSMA and AMA.

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Councilor Commentary



Sixth District

J. James Anderson, MD

Throughout his many-tiered involvement in organized medicine, J. James Anderson, MD, a Youngstown pediatrician, has never lost sight of the principle that "the physician is the patient's advocate."

This is just one insight that propels Dr. Anderson in his role as councilor for the OSMA, and, why, since the early 1960s, he has made it a priority to be a part of the inner workings of organizations such as the OSMA.

After receiving his MD degree from the University of Cincinnati in 1956, Dr. Anderson interned at the Youngstown Hospital Association, and then completed a pediatrics residency at the University Hospitals in Cleveland. He was named a diplomate to the Board of Pediatrics in 1961, and, the following year, was named a fellow of the American Academy of Pediatrics.

In 1961, after setting up a private practice in pediatrics in Youngstown, he began his involvement in a variety of other medical activities. He has been an attending physician at the Youngstown Hospital Association and a clinical assistant professor of Pediatrics at Northeastern Ohio Universities College of Medicine. He has also been a member and past-president of the Mahoning County Medical Society, as well as alternate delegate and delegate to the OSMA.

Today, along with his duties as Sixth District Councilor, Dr. Anderson maintains his pediatrics practice in Youngstown and is a co-director of the Pediatric Ambulatory Care Center located there.

He describes the district he represents, which includes Columbiana, Mahoning, Stark, and Trumbull Counties, as a combination of both rural and metropolitan areas. The district is representative of the state as a whole as far as the influx of alternative delivery systems, the ramifications of the malpractice issue, and the concerns about third-party intervention and competition, Dr. Anderson says.

In fact, it's not surprising that Youngstown might especially feel the crunch of competition. Since Dr. Anderson first launched his own practice, Youngstown has undergone a succession of economic changes due, primarily, to the loss of the once successful steel mills. And, as a result, factors such as urban flight, loss of population and higher unemployment may all contribute to a thinning patient base.

In addition, alternative health care facilities such as HMOs tend

"The definition of malpractice is too flimsy; it doesn't separate the category of 'bad' practice from 'bad' results . . ."

to inflame the competitive atmosphere. And, although the private practitioner continues to thrive in his district, Dr. Anderson says other types of practices are certainly visible. "Like the rest of the state, PPOs, HMOs, etc., are existing side by side with private practices," he says.

And the answer to crucial questions that are being asked all over the state — Can this juxtaposition last? Can these practices coexist peacefully, and, if so, for how long — have yet to be answered.

But one thing that appears obvious is that concern over these questions continues. "Private practitioners are certainly concerned about how the different forms of health care are going to coexist," Dr. Anderson says.

Another concern in the Sixth District — which has been rattling nerves and pocketbooks all over the state — is the issue of malpractice and rising liability premiums.

First of all, Dr. Anderson points out, the definition of malpractice is too flimsy; it doesn't separate the category of "bad" practice from "bad" results, which may or may not be the practitioner's fault.

"We must work with the legislature to modify the tort system so that so many frivolous suits can't be filed," he suggests. Because, eventually, the problem of malpractice and high premiums may start to encroach on the entire spectrum of health care delivery.

Another possible encroachment, according to some Ohio physicians, comes in the form of government intrusion such as the DRG perspective payment plan, says Dr. Anderson. "There's a concern about what these kind of things can do to the overall quality of medicine," he points out.

The DRG system also has the potential of stirring up trouble between the hospital and the medical staff — and although this isn't a major problem in his district yet, says Dr. Anderson, it could be if the current reimbursement system continues.

Finally, Dr. Anderson points to the positive steps which are being taken in his district — projects such as the mini-internship program and the public education campaign, which was initiated by the OSMA Communications Department. Patient education is extremely important, says Dr. Anderson, because it's essential that "patients know what is happening to their health care."

After all, one of the main functions of organized medicine is to explore avenues which can enable the physician to better care for his or her patients.

And, in order to accomplish this, says Dr. Anderson, physicians must join together. "Organized medicine is a tremendously important facet of medicine. There's no way we can provide good health care for patients unless we join together in a unified manner." — *Deborah Athy*



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vicodin® III

hydrocodone bitartrate 5 mg (Warning: May be habit forming.)
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Brief Summary

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydracodane.
WARNINGS
Drug Abuse and Dependence: VICODIN is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydracodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982.

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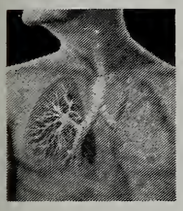
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Effective and versatile *b.i.d.* therapy

Before prescribing, please consult complete product information, a summary of which follows:

CONTRAINDICATIONS: Hypersensitivity to trimethoprim or sulfonamides; documented megaloblastic anemia due to folate deficiency; pregnancy at term and during the nursing period; infants less than two months of age.

WARNINGS: FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently.

BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS:

General: Give with caution to patients with impaired renal or hepatic function, possible folate deficiency and severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur, frequently dose-related.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently; if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffé alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenesis: Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. *Mutagenesis:* Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. *Impairment of Fertility:* No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folic acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS and CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).** *Hematologic:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, methemoglobinemia, eosinophilia. *Allergic Reactions:* Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. Periarteritis nodosa and systemic lupus erythematosus have been reported. *Gastrointestinal:* Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. *Genitourinary:* Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. *Neurologic:* Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. *Psychiatric:* Hallucinations, depression, apathy, nervousness. *Endocrine:* Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. *Musculoskeletal:* Arthralgia, myalgia. *Miscellaneous:* Weakness, fatigue, insomnia.

DOSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN: *Usual adult dosage* for urinary tract infections is one DS tablet, two tablets or four teaspoonfuls (20 ml) *b.i.d.* for 10 to 14 days. Use identical daily dosage for 5 days for shigellosis. *Recommended dosage for children* with urinary tract infections or acute otitis media is 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses every 12 hours for 10 days. Use identical daily dosage for 5 days for shigellosis. *Renal Impaired:* Creatinine clearance above 30 ml/min, give usual dosage; 15-30 ml/min, give one-half the usual regimen; below 15 ml/min, use not recommended.

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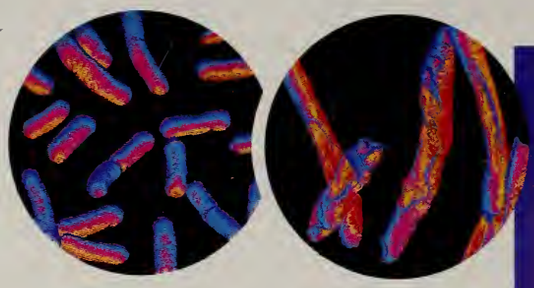
HOW SUPPLIED: *DS (double strength) Tablets* (160 mg trimethoprim and 800 mg sulfamethoxazole—bottles of 100, 250 and 500; Tel-E-Dose* packages of 100; Prescription Paks of 20. *Tablets* (80 mg trimethoprim and 400 mg sulfamethoxazole)—bottles of 100 and 500; Tel-E-Dose* packages of 100; Prescription Paks of 40. *Pediatric Suspension* (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 100 ml and 16 oz (1 pint). *Suspension* (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 16 oz (1 pint).

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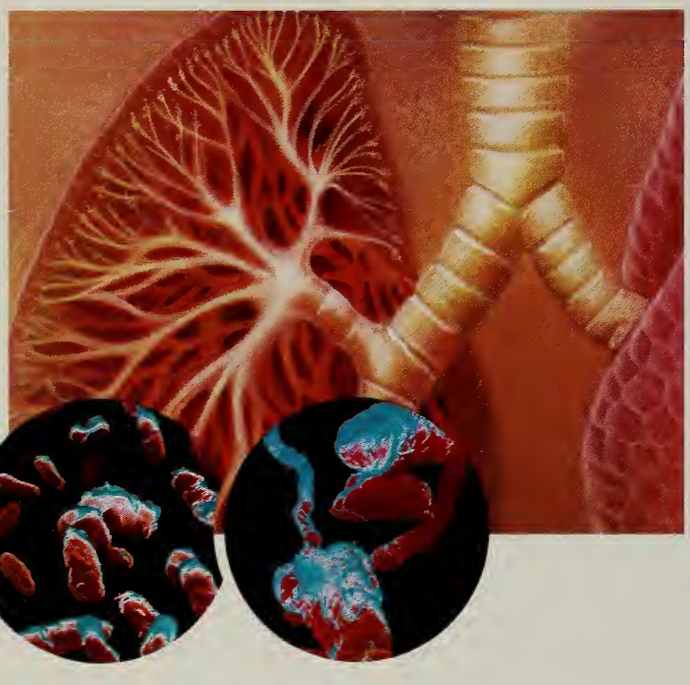
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before Otoscopic view of tympanic membrane in a patient who did not respond to ampicillin therapy.

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Please see preceding page for a summary of product information.

THE Ohio STATE Medical Journal

VOL. 82, NO. 5, MAY 1986

- Anger. Dangerous Enemy, Powerful Ally
- Doctor: Are You Being Duped?
- "I Trained with the Reds"

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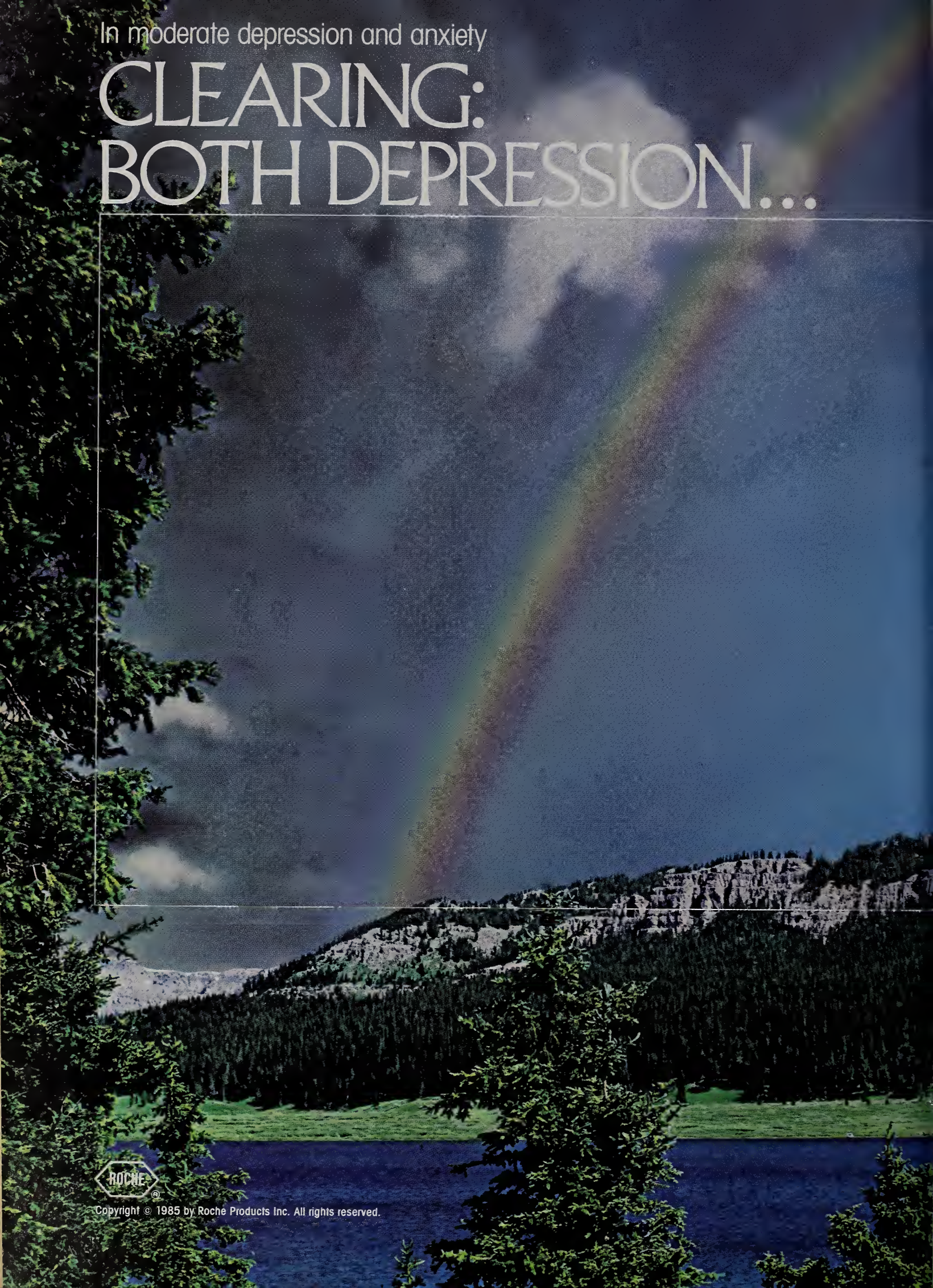
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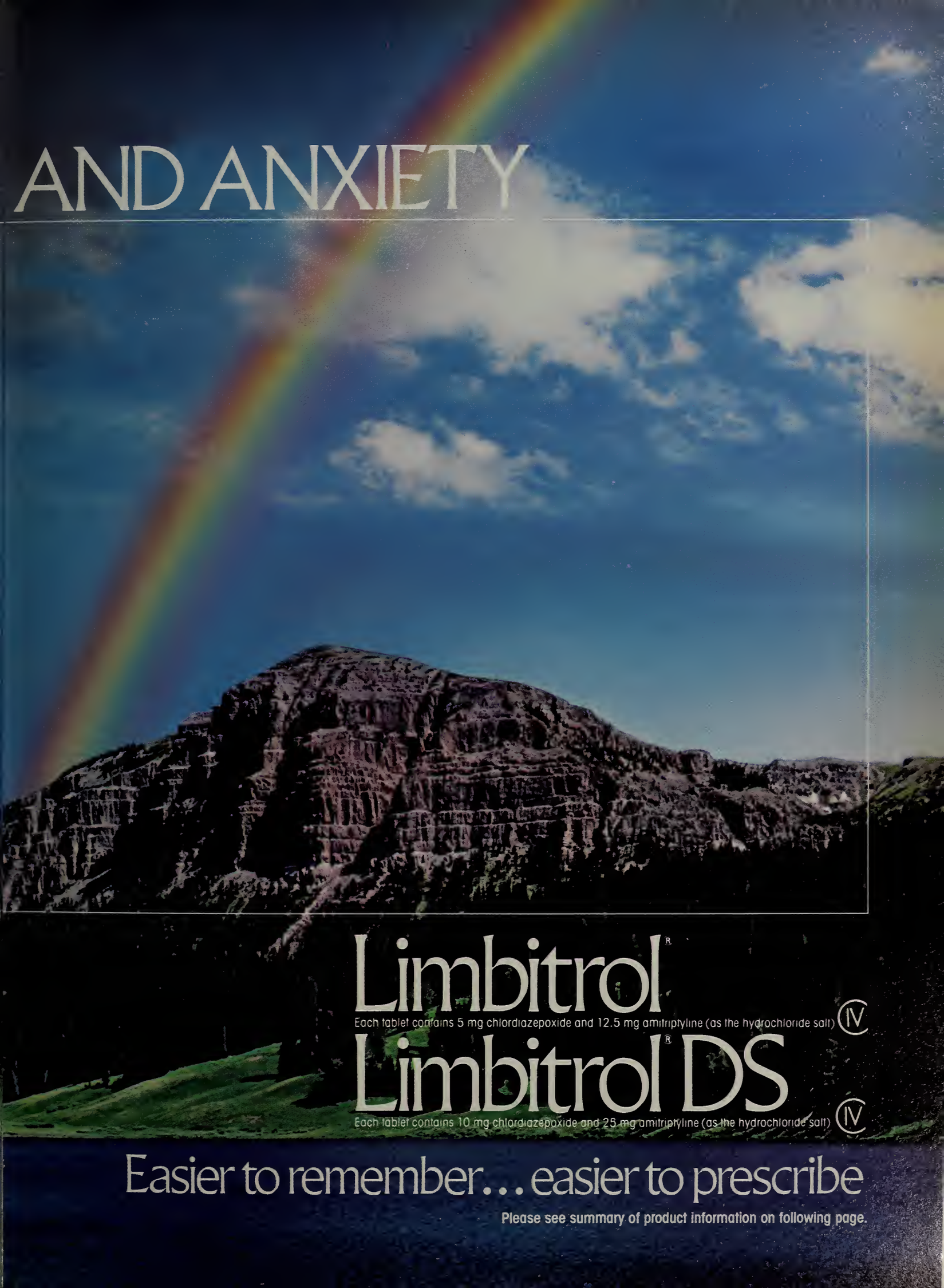
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Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for monitestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.
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Herman I. Abromowitz, MD

A SPECIAL THANKS

During this past year, I've attempted to bring forth various concerns that I believe face all of the physicians of Ohio and the patients we serve. In this, my final Presidential Perspective as President of the Ohio State Medical Association, I should like to extend a special and sincere thanks to the many individuals who have performed with great dedication during my term of office.

My fellow Officers and Councilors have certainly shown great dedication of purpose and have worked diligently on behalf of our Association and our membership. To each, I offer my humble thanks and sincere appreciation.

To my wife, family, friends and associates, this year could not have been possible without their understanding and personal support.

Presidents who have preceded me and those who will follow will certainly experience the uniqueness that I have had in working in close association with our absolutely outstanding staff at the OSMA. I urge each physician to become more involved and acquainted with our very talented staff. They serve our Association with great distinction and dedication.

This outstanding staff is headed by our new Executive Director, Herbert E. Gillen, and his Deputy Director, D. Brent Mulgrew, who indeed are "the greatest." Their "rookie year," following in the steps of the legendary Hart F. Page, has proven to all of us that they have the great leadership and outstanding qualities that will make OSMA rise to even greater heights in the future.

I could indeed describe each and every staff person with outstanding accolades. But, in this final Presidential Perspective, I want to offer my personal and deep appreciation to each and every member of the OSMA Staff. The OSMA Staff is certainly professional in every respect and I would like to publicly thank each of them for their quality and determination in dedication of purpose in my personal behalf and in behalf of our Association.

I realize that my year at the helm of the OSMA has grown to a close. Although much has been accomplished this year, I feel, as every President must, that there are many more "mountains to climb" and challenges to be met. In turning my gavel over to Dr. John E. Albers, I know our Association is under excellent leadership and that he will carry forth the purposes of our Association with great expertise and great dedication.

I leave the Office of President of the OSMA with a deep sense of pride because I have been so impressed with the dedication and determination of our membership.

This past year I have made a sincere effort to communicate with every individual physician of our Association and with every community.

In traveling extensively throughout Ohio this past year and meeting with the medical leadership of our respective counties and districts, let me with pride assure all that the physicians of Ohio do put quality of medicine first and foremost and are, indeed, caring physicians. I am proud and honored to have been of service and I extend my personal and heartfelt thanks to each and every member of our great Association for the trust you have bestowed upon me as your President. ***A special thanks to all.***

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(b). A copy of the manuscript should be retained by the Author.

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Malpractice in Ohio — Hot or Not?

You've no doubt heard about the cresting crisis in professional liability. It's being called a "crisis of affordability" to separate it in the minds of all those who survived the malpractice "crisis of availability" which took place about a decade ago.

But how real is this crisis? Has it been exaggerated beyond reason, or does it, in fact, raise some legitimate concerns? Several months ago, the Ohio State Medical Association sought to answer this question by polling all of you on the subject of premiums, malpractice cases you've experienced and so on. Our cover story this month, then, examines the results of this survey — presenting a look at malpractice in this state from your perspective. It will be followed, in future issues of the *Journal,* by other aspects of the "liability crisis" — a national overview, a state overview, proposed legal and legislative remedies and educational efforts. (Those attending this year's Annual Meeting will be able to obtain a "sneak preview" of these articles.) By the time you have finished reading the series, you'll be able to come to your own conclusions on the malpractice crisis of the '80s. In the meantime, the best answer we can give you is . . . wait and see.

This month, you may also notice that this issue's contents are slightly different than usual. Instead of the highly focused, single-subject articles we typically run, you'll find this issue more of a "mixed bag" — an assortment, if you will, of what is going on in Ohio medicine, both scientifically and socioeconomically. Consider this mixed content a trend. Thanks to the number of responses we received to the "We Need Your Help" survey which was mailed out through the OSMAgram several months ago, the *Journal* will be changing its format somewhat to allow for a greater variety of articles in each issue. In addition to using articles suggested — even written by those who responded to the survey — we will be soliciting "state-of-the-art" articles from the specialty societies; incorporating a clinical "question-and-answer" column; running physician-authored reviews of current medical books; and in this issue, we are introducing a new department entitled "Out of Practice," in which we will introduce to you a colleague of yours who has an especially interesting hobby or pastime which he or she pursues when they are outside their regular practice hours.

We hope that the greater range of contents in each issue will not only attract the attention of more readers each issue, but will also allow more of you the opportunity to participate as contributors and authors.

So, this issue, enjoy Dr. Francine Rasco's article on "Healthy and Unhealthy Ways of Dealing with Anger" (Dr. Rasco was a "We Need Your Help" respondent); Communications Director Carol Mullinax's article on "Drug Scams: Are You a Victim?"; and Dr. V.N. Carrico's, "Out of Practice" article — "I Trained with the Reds." A mixed bag, you'll agree — but one we think you'll find enjoyable. — *Karen S. Edwards*

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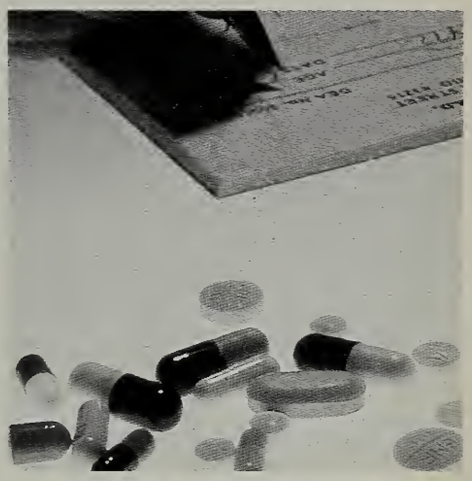
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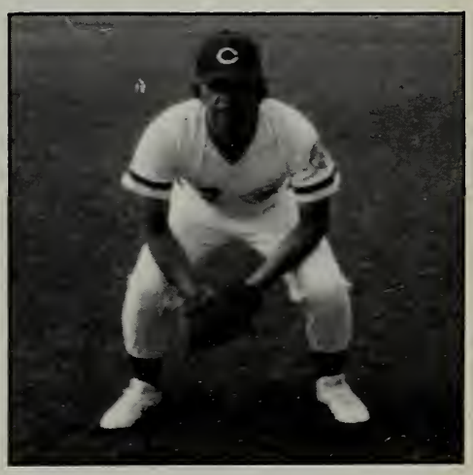
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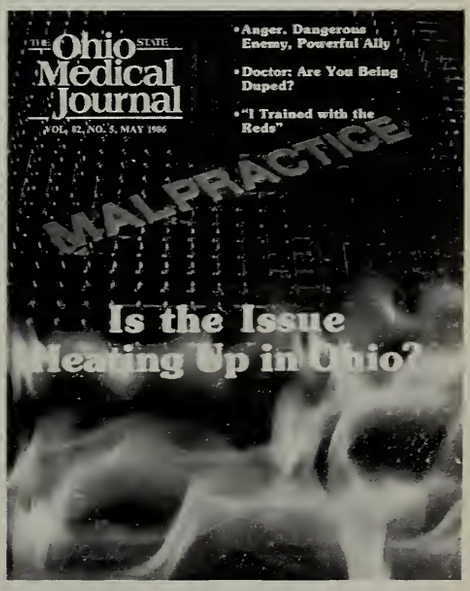
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Introspection

By Juan A. Ruiz, MD

This article is reprinted from the Bulletin of the Mahoning County Medical Society with the permission of the author.

During the last year I have had the occasion of viewing our medical society from the inside out as president of the Mahoning County Medical Society and observing some problems and difficulties from that perspective. Last Tuesday night, I became convinced of the insight of the cartoonists who during World War II said, "We have met the enemy, and the enemy is us."

For a year I have presided at meetings of the Council of the Mahoning County Medical Society and of the society as a whole, and have watched with a sinking heart the declining attendance. At times, the meetings could not be held because of what appears to be insensitivity of the medical staffs of our hospitals — meetings of the staff were scheduled in conflicting times with the business of the society, in spite of the fact that the dates of our society meetings and the meetings of the council are fixed and known far in advance by all concerned.

On multiple occasions physicians have asked me, "What is the medical society going to do about this particular problem?" Invariably, the physicians asking the question are the ones whose presence was never noted at the meetings of the medical society. In spite of the fact that through the year, both myself and the editor of the bulletin attempted to bring up controversial points with the deep desire to stir up the conscience of the membership, only on very rare occasions would anyone acknowledge having read the columns and expressing either agreement or disagreement.

Even more recently, at the time of the outrageous incident in the Youngstown *Vindicator* regarding the patient who died victim of AIDS, some physicians approached me in slightly larger numbers with the all too often used question, "What is the medical society going to do about this?" To my knowledge, not a single one of them wrote a letter to the *Vindicator,* or addressed a letter to our society office; and when I wrote about this, only one member of the society took notice and stood behind me for what I said.

Through the entire year the only time that we had a meeting of the society with significant attendance was when a subject matter that had importance from the point of view of the financial concerns of the physicians was to be discussed. It is noticeable that the physicians who are members of the council are the same ones that attend the society meetings on a regular basis, and have been the faithful ones there for nearly all the years that I have been a member of the society, with some few more recent additions.

Yes, indeed, our enemy is us. Our enemy is our apathy and our indifference. Our enemy is the complacency and the letting somebody else take over the responsibilities that we once assumed. No longer is the medical society stirring up the conscience of the public and leading the fight for the public good, nor is the society involved in what even remotely smells like concern for the general public health.

We have relinquished, for the sake of our convenience and comfort, the running of our profession to the nurses, supervisors, hospital administrators and para-professional societies — the responsibilities and the rights that by tradition belong to us. Instead

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"Do not sit back and let less than five percent of the members make all the decisions of the society."

Introspection

continued

of being in the forefront of the news raising up our standard and concern for life and helping to change the moral trends of our time, we have joined forces with those whose philosophy of expediency denies the right to life to the unborn, even negating his humanity, and have become complacent in treating as expendable the elderly and infirm because they are burdensome and costly. While we pay lip service to a belief in God, we are very careful to make sure that nobody knows about this in public, lest we appear sissified, ridiculous or unlearned. We no longer initiate the business of our meetings with a time of prayer or an invocation prior to our dinners, and when this is actually performed, we exercise care to delete that particular even from the official recording of the business transactions.

I remember with sadness and nostalgia the days when the meetings of the medical society were vibrant, when our members were men and women whose vision was not limited to their personal gain or grandioseness, but extended beyond the local hospital, city, county, and even the state. When a physician was viewed as a man of compassion and courage, of character and integrity, who respected life, and whose primary concern was always the welfare of his patients; and whose morality, medical philosophy and religious faith constituted the very fabric of his personality, and, indeed, shaped his behavior toward his patients, his peers and his community.

In other words, they were men of high ethical consciousness and practice, who were the recipients of public trust and whose opinions were often requested and respected. It is obvious that the erosion of our ethical and moral standards, while it apparently has infected a large number of those graduating from medical schools, has not yet become an epidemic which includes everyone.

We do have dedicated men and women of high ethics who labor for the good of the society and who frequently are maligned, oftentimes accused, and most of the time totally unrecognized and, characteristically, unthanked for their dedication. My expectation is that something other than financial considerations will arouse the worthwhile men and women who are members of our society but whose voices have not been heard yet, and that they will join ranks with those who have been laboring so consistently for so long.

To the younger generation of physicians, and to those not so young that have not yet decided to let their voices be heard, I challenge you to join and participate. Infuse the society with youth and vigor and new ideas. Do not sit back and let less than 5% of the members make all the decisions of the society, including the nomination and election of officers.

You want changes, make the changes. I hope my words have irritated some of you to try to prove me wrong. Come and be an accountable member. In other words, "Put up or shut up."

For those of you who have lovingly and consistently worked so hard, I have nothing less to tell you than the encouragement given by St. Paul: "So let us never tire of doing good, for if we do not slacken our efforts we shall in due time reap our harvest" (Galatians 6:9).

Juan A. Ruiz, MD, is president of the Mahoning County Medical Society.

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News Digest

Edited by Deborah Athy



Repeated ear infections may cause children to have trouble in school

Repeated cases of otitis media (middle-ear infection), one of the most common ailments of pre-school children, may lead to poorer language skills and shorter attention spans in school, says a study conducted by the University of North Carolina.

The study, part of a larger project on day-care diseases, tracked 44 day-care children from 3 months to 7 years of age. Researchers found that the 13 children who had nine or more ear infections in the first three years had significantly poorer narrative skills at ages 5 and 7 than other children.

Narrative skills were measured by telling the children stories, asking them to paraphrase the content and then counting how many crucial elements were included in the child's version.

In addition, the 13 children had twice as many periods of classroom inattention as the other 31 children studied.

"This habit of not attending may have been created because listening and understanding takes greater effort for children with a hearing loss," says the study's researchers.

The infection often includes fluid buildup, which can cause mild to moderate intermittent hearing loss that can last up to nine months after the infection clears.

America's health update

Americans are enjoying healthier and longer lives than ever before, says a recent government report on the nation's health. But, like most everything else, "good" health has its price.

According to the report, the average cost for health care per year for Americans is $1,580 apiece. That's three times the amount spent ten years ago, the report adds.

Other points of interest:

• Life expectancy at an all-time high.

A child born in 1983 can expect to live on the average of 74.6 years. The longest life expectancy is 78.7 years for white females; the shortest, black males, 65.4.

Man and woman of the 1980 variety have gained about three and four and one-half more years respectively than their 1950 counterparts.

• Infant mortality rates

Infant deaths fell to an all-time low of 10.6 per 1000 in 1984.

However, there is still concern about the gap between the rate at which white and black infants die — black infants are twice as likely to die in their first year as white infants, the report states.

• Smoking losing its allure for some

In 1965, more than 50% of all males were puffing away. Today, that number has shrunk to about 35%.

a compilation of the latest developments, reports and products of interest to physicians.



Taking the starch out of lawsuits

Developing a better doctor-patient rapport offers more hope for easing the medical liability crisis than relying solely on reforms in the legislative system, according to William L. Turner, a Kansas City attorney who specializes in defending medical liability suits.

"Patient education is a marvelous vehicle to achieve this rapport," Turner says in a recent article in the *AAFP Reporter.*

Instead of receiving "informed consent" from patients for medical treatment, physicians should try to establish an "informed treatment" system, Turner suggests. For example, make the patient a part of the treatment team by providing information about the illness, treatment, alternatives and risks, and then letting the patient make a request for treatment, he says.

A request for treatment indicates an active role, where consenting to treatment represents a passive role, Turner points out. It is a difference in psychology that also makes a difference in court, he says.

"We know that health care providers have done a very poor job of providing information to the patient," Turner says. "Or at least they have done a poor job assessing whether patients comprehend the information."

A successful doctor-patient rapport means that patients understand the kind of treatment they're receiving, and that they feel free to ask questions and discuss problems with their physicians, he continues.

As a general rule, "plaintiffs don't sue friends or entities they have any feeling for," Turner points out. By developing a good rapport with their patients through education and communication, physicians may be able to tip the scales of justice in their favor.

Health care horoscope, 1986

Anticipate a departure from tradition. *Beware* of a surge of large, for-profit medical corporations. *Expect* an increase in do-it-yourself-at-home health care.

So says *Megatrends* author John Naisbett in his latest novel which takes a peek at *The Year Ahead 1986.*

"America's health care delivery system is in a tumultuous period of transition," according to Naisbett. As a result, a whirlwind of mega-changes are brewing on the edge of the medical horizon, he continues.

Naisbett bases his latest predictions — such as the soon-to-be prevalence of home health care and centralized health corporations — on current trends. Some of these include:

- One hospital in five is now owned or operated by an investor-owned health care deliverer.
- One in three non-profit hospitals is attempting to form chains or conglomerates.
- Emergicenters and surgicenters treat some 45 million patients every year.
- Walk-in clinics have increased from 260 in 1981 to more than 2,500 today.
- A recent survey's results indicate that most common health problems are no longer treated by a doctor, and, consequently, that Americans are beginning to see to their own health and fitness.

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Ohio medi-scene

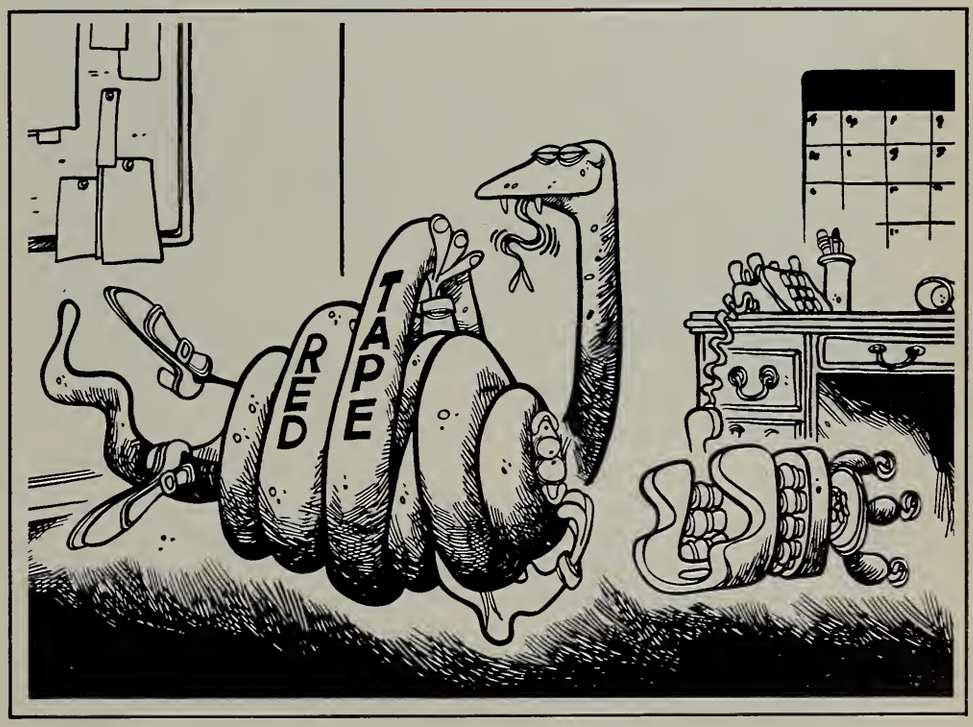
Medicare misunderstandings . . . new cancer treatment . . . a day at the legislature . . . help for tinnitus . . . bikini incision in heart surgery

Managing Medicare misunderstandings

You've just treated a Medicare patient and reviewed with her the medications you've prescribed for her and the date she is to return for her next appointment. But she's reluctant to leave, and you suddenly realize she has more on her mind than her arthritis, diabetes and osteoporosis.

If she's like most older patients, she may be troubled because she isn't sure how to fill out and submit that complicated batch of forms that Medicare reimbursement requires. And even though she also carries a supplemental insurance policy, she's embarrassed because she can't seem to collect from it what she needs — and you haven't been paid for quite some time.

The problem is such a critical one that the Health Advocacy Services of the American Association of Retired Persons (AARP) is now involved in an intensive effort to help older patients learn to deal with the paperwork involved both with Medicare reimbursement and with supplemental insurance. To date, the work has been a real eye-opener, says Lois Morris, an associate advocate of the Health Advocacy Services and president of the Ashland Area Chapter of the AARP.



"We've been in homes where literally thousands of dollars in Medicare and insurance checks have been received," she says. Yet because the recipient didn't understand that the check had to be torn off from the statement form, these checks were stuffed away in drawers and boxes and even thrown into waste baskets.

In addition, many seniors "don't realize that they are supposed to take this check and pay their doctor," Morris says. Many think that every physician is reimbursed directly for Medicare, while only those who accept assignment are paid directly from the fund. The rest rely on the patient to take care of this matter — and approximately 40% of all physicians never see their money, says Morris — not because their patients are dishonest, but because they don't understand the system.

To help clear up some of these misunderstandings and to teach older people how to cope with

Ohio medi-scene . . . continued

Medicare misunderstandings . . . *continued*

Medicare, the AARP started a pilot project in the Cincinnati area back in 1981, says Al Boffo, a past state director of the AARP and state coordinator of Health Advocacy Services. Since that time, the program has been expanded to a number of other counties, and it is Boffo's goal to make sure that it eventually is available to every senior citizen in the state.

According to Morris, the program is totally comprised of volunteers in the community who have received three days of special training from Medicare attorneys hired by the national AARP. "The idea is that it's to be a community project — not just an AARP project," Morris says.

These trained individuals then make themselves available at local senior centers, in hospitals and in other public and community buildings frequented by older people, and work on a one-to-one basis with those having problems.

In special cases, they will even go into an elderly person's home to help straighten out the mass of past-due bills and Medicare misunderstandings; but, in most instances, they ask the individual to bring his or her paperwork to a designated center. "One man spent six hours in our office" clearing up his maze of paperwork, Morris says.

The most common area of confusion surrounding Medicare are the copays, deductibles — what is paid and what isn't paid. Many senior citizens have been sold supplemental policies to cover these; however, they frequently don't understand how to submit the claims for the reimbursement they are due. Rather, they often submit the supplemental policy and Medicare forms at the same time, and then are turned down by the insurance company because Medicare already covers the claim, Morris explains.

"What they need to do," says Morris, "is to submit the claim to Medicare first, and then submit to the insurance company that portion that was not covered." In addition, the volunteers will help older individuals critique their supplemental policies explaining what is covered and what is not covered under their particular plan.

The AARP advertises the program with special signs and posters displayed in areas they are likely to be seen by senior citizens and in doctor's offices. However, William M. Emery, MD, a member of the OSMA Committee on Geriatric Medicine, fears that not enough elderly persons — nor physicians — know about the program. "And some of these centers are complaining that they have no clients," he says.

In Ashland County, where Dr. Emery practices, the county medical society is helping to promote the program which is offered at the Ashland YMCA, Samaritan Hospital and the Council on Aging. Physicians who refer their patients to those locales, says Dr. Emery, may save themselves a lot of time and money — and save their patients from embarrassment and headaches.

According to Boffo, the AARP is even willing to send volunteers directly to a physician's office to sit down with his or her patients and discuss the Medicare billing and reimbursement system, as long as parking, office space and a copy machine are provided.

The following are the state's volunteer coordinators of the program:

Cincinnati
Bernice Nies
8500 Miami Rd.
Cincinnati, Ohio 45243
(513) 791-0707

Columbus
Thelma Martin
293 S. Cypress
Columbus, Ohio 43222
(614) 464-1769

Mansfield
Margaret Epps
350 Altamont
Mansfield, Ohio 44903

Akron
J.H. (Jim) Johnson
P.O. Box 8244
Akron, Ohio
(216) 867-6838

Canton
Edith Abramson
230 36th N.W.
Canton, Ohio 44709

New Philadelphia
William Wheeler
1271 Independence Dr. S.E.
New Philadelphia, Ohio 44663
(216) 339-1448

Fremont
Debra Haubert
250 C.R. 94
Helena, Ohio 43435
(419) 638-5731

Realistically speaking, says Morris, some patients will never

be able to handle the complications of Medicare. These are the disabled, the blind, and those who suffer from Alzheimers. But for those who can, it may only be a matter of sitting down and explaining the system. — *Susan Porter*

Second Ohio hospital to use new cancer treatment

Miami Valley Hospital in Dayton has become the second hospital in the state to acquire and use a state-of-the-art hyperthermia unit for treating cancer patients.

Hyperthermia uses microwave and ultrasound capabilities to deliver heat to the tumor site. In a recent newspaper interview, Robert Fields, MD, medical director of radiation therapy, says the new unit will "enable doctors to increase — in some cases, double — the response and regression rates for many tumors."

Results from a recent worldwide study reveal a 65 percent complete regression rate for 851 patients who underwent hyperthermia treatment in conjunction with radiation therapy. That compares to a 25 percent rate with radiation therapy alone.

Hyperthermia is supposed to be especially effective in treating breast cancer and in treating difficult or inoperable tumor locations, such as on the neck or head.

Ohio legislators are guests of the Ohio State Medical Association Auxiliary



photo by Holly Slivinski

The Ohio State Medical Association Auxiliary held its annual "Day at the Legislature" on March 5, 1986, at the Sheraton Hotel in Columbus. The agenda for the day included briefings on current federal and state legislative issues; luncheon with the legislators; and an afternoon seminar, "How the Grass Roots Can Make Hay in a Political Campaign." The seminar, held with a panel of experts, provided the tools and opportunity to be an effective participant in the 1986 elections on behalf of the candidate of his or her choice. OSMA Auxiliary members are proving that legislative action can be interesting and rewarding for them, while providing a real service to the medical community.

Luncheon with the Ohio Legislators is the highlight of the day. A few years back the 35 auxilians, at the luncheon, were outnumbered by the legislators. At this spring's luncheon, organized by the 1985-1986 OSMA-A Legislation chairman, Barbara Marshall, (Montgomery County), there were 90 auxilians and 72 legislators in attendance. One of the representatives has said that he wouldn't miss the luncheon for anything. "It's not a business luncheon; it's a social opportunity with fringe benefits!"

Auxilians from 24 counties around the state look forward to meeting their representatives and senators, getting to know them better, and discussing issues of interest to both. — *Sally Lewis*

Ohio medi-scene . . . continued

New help for tinnitus

The constant sound of ringing has become a joy to Nancy Rabinowitz and others involved at the Tinnitus Center of Greater Cincinnati, which recently opened at Providence Hospital. Since its start on February 3, the center — only the second of its kind in the country — has received calls and examined patients from several states and all over the Greater Cincinnati Area. "At first we were a little afraid that no one would call," Rabinowitz, an audiologist and director of the new center, recalls. "But the response has been tremendous — the phones have never stopped ringing," she says.

This high level of interest may also be a sign that tinnitus — described as a ringing, buzzing, whistling, roaring, hissing or high pitched screeching in the ear — may be more prevalent than originally thought. The National Institutes of Health estimate some 36 million Americans suffer from the condition and 7.2 million have it in a severe form — figures already alarmingly high to those who work with tinnitus patients.

Because tinnitus is an invisible condition, many people don't realize they have it, and most simply ignore it, Rabinowitz says. And because the source of the noise is still not understood, very little in the past has been done to attempt to silence it.

Thus, until recently, little could be done for those forms of tinnitus that did not have another medical problem at their root, such as a tumor, wax against the ear drum, ostosclerosis or Meniere's disease. Also, some forms of medication, including aspirin, may cause a ringing in the ear, as will head injuries. In these cases, the tinnitus generally disappears when the underlying problem is treated.

However, the most common form of tinnitus is that which accompanies some level of hearing loss due to a variety of causes, including past ear infections and constant exposure to loud noise. Even totally deaf individuals have been known to suffer from tinnitus, says Rabinowitz.

"We think it's like the phantom missing limb," says Gale Miller, MD, a Cincinnati ear specialist who helped start the program at



Providence Hospital. Ironically, the sound the individual hears inside his or her head often is the same tone or pitch the ear is no longer able to pick up. "Because there is no sound coming from outside the ear, the nerves may be firing on their own to compensate," Dr. Miller speculates.

There is no cure for this type of tinnitus, Dr. Miller admits. "And I don't see any immediate breakthroughs," he adds. However, some things can be done to help those severely bothered by the ringing to cope with it. "Most of the time, tinnitus is something people can put up with," says Dr. Miller. "But for some patients, it can be an overwhelming problem. They just can't seem to live with the constant sound."

It was his frustration at not being able to help this type of patient that led Dr. Miller, along with Rabinowitz and Earl Gilreath, president of Providence Hospital, to pay a visit to Portland, Oregon — at that time, the location of the only tinnitus center in the U.S. "We were very impressed," says Rabinowitz, "because the center really seemed to be helping patients."

Among the major techniques used to help individuals cope with tinnitus is "masking" — the patient identifies the exact sound he or she is hearing, and then the sound is reproduced by a synthesizer and played back into the ear through a device which looks like a hearing aid. The masker actually generates a band of noises, in an attempt to cover up the tinnitus and make it more bearable.

While this technique does not work for everyone, a number of patients have been helped by masking, says Dr. Miller. Some even find the noise is gone when the masker is removed. And for those patients with hearing aids, a masker can sometimes be incorporated into that device.

Another method used to help patients with tinnitus is biofeedback. "People can be taught to relax the muscular structure around the head," says Dr. Miller, which may help to alleviate the tinnitus. Whether or not the sound actually disappears or simply becomes less irritating is still not understood — but in many cases, this and other relaxation techniques at least make tinnitus easier to live with, he says.

Before a patient will be seen at the Tinnitus Center in Cincinnati, he or she must first have a complete work-up by an otolaryngologist to make sure there is no medical cause for the problem. "We don't want to be masking the symptoms of a tumor," says Dr. Miller.

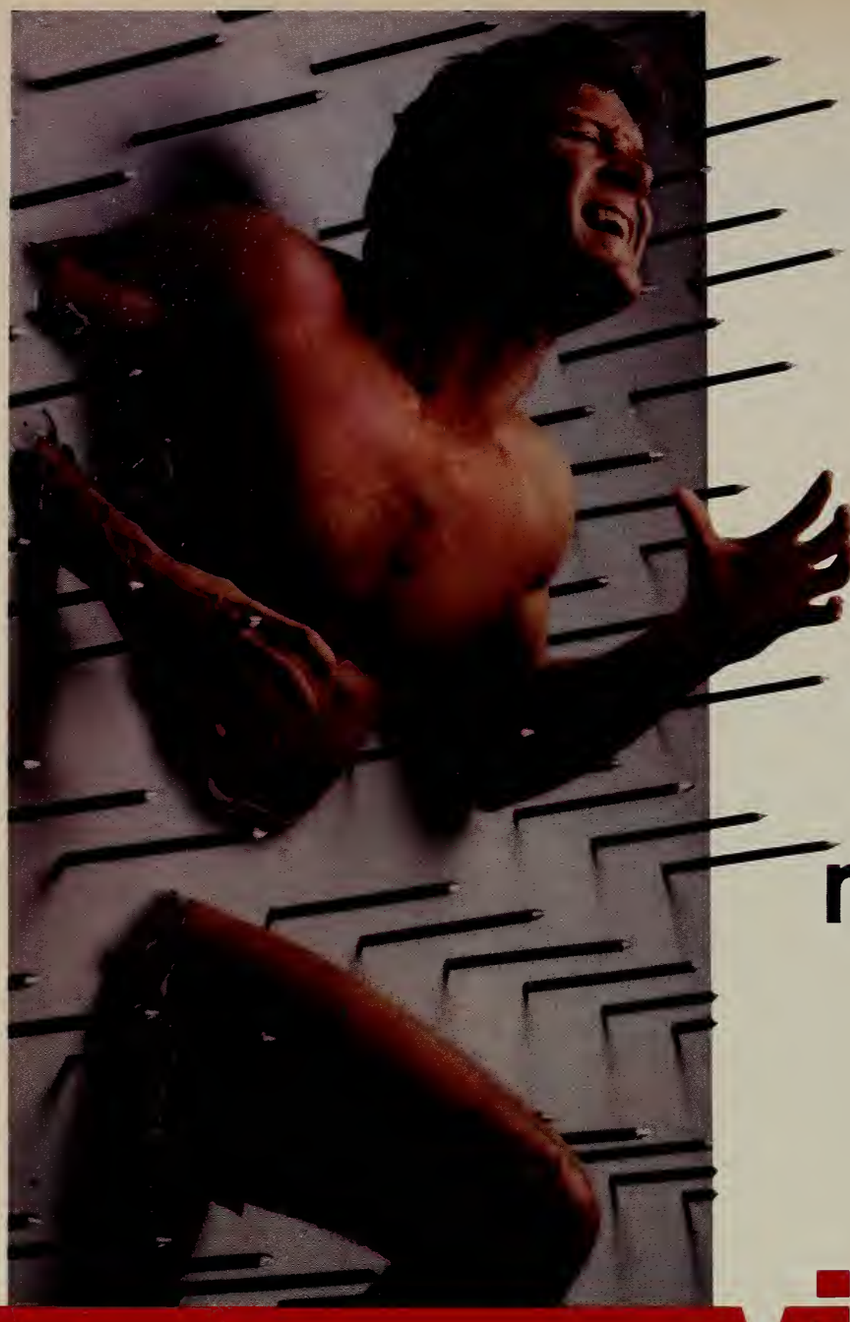
Once accepted at the center, patients go through a series of tests, in which they are helped to identify the exact sounds and tones they are hearing. They also are asked to fill out a lengthy questionnaire regarding the conditions surrounding the tinnitus, its intensity and severity, its consistency and the amount of disability it is causing. Through these surveys, the center hopes to build a backlog of information which might be used in future research efforts, Rabinowitz says, although the center is chiefly treatment-oriented.

"We are finding that most of the people who come into the center for information or evaluation hear the ringing all or most of the time," Rabinowitz says. "A number of them have worked in factories or around other loud noises. And most of them suffer from a hearing loss, as well as from the buzzing or ringing."

Patients may be self-referred, physician-referred or company-referred, Rabinowitz says. "We have had several calls from the parents of teenagers who have tinnitus from listening to loud music," she adds. "But most of the people with tinnitus are middle-aged or older."

In the past, she says, physicians whose patients complained of tinnitus had no alternative but to tell them they simply would have to learn to live with this annoying sound, she continues. "Even if you were referred to an ENT, you generally were told there was nothing that could be done for it," she says.

According to Dr. Miller, a lot of superstition surrounded tinnitus in the past. "Several generations back it was known as 'death bells,' " he says. "People would hear these sounds that no one else was hearing and think it meant they were going to die." Thus, it



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Ohio medi-scene . . . continued

Help for tinnitus . . . *continued*

wasn't a condition people liked to talk about.

Today, patients often come into Dr. Miller's office with other ear problems, and in the course of the examination, admit to having tinnitus, as well. Quite frequently, he says, they're surprised that a ringing in the ear is not normal. "Doesn't everyone have it?" they tend to ask. For them, tinnitus is obviously not a major problem, he says.

However, there are some patients who, according to Dr. Miller, "will demand referral or some sort of help. They are extremely troubled by the problem, and they will do almost anything for some relief."

It is these patients that the Tinnitus Center most likely will be able to help. One patient, says Dr. Miller, seemed tremendously relieved just to be able to identify the sound he was hearing on the tinnitus synthesizer. "I'm not sure why, but for some reason, he got a lot of satisfaction from being able to tell people what he was listening to," he says.

Dr. Miller suggests that those patients who are so bothered by the ringing that they cannot sleep at night, or those whose tinnitus disrupts their normal daily activities, should be referred to the center, which serves not only Cincinnati but the entire eastern half of the United States.

"If the problem is not debilitating, then it's probably best to ignore it," he says. "But for those patients who find it so annoying that they can no longer think or concentrate, the center may be able to help them find some relief." — *Susan Porter*

The Tinnitus Center of Greater Cincinnati at Providence Hospital can be reached by calling (513) 853-5720.



Aesthetic perspective in heart surgery

Anymore, the "bikini incision" technique is not "earthshaking from a scientific point of view," says J. Terrance Davis, an associate professor of surgery and pediatrics at the Medical College of Ohio.

But *what is* unusual about this technique is when it is used in heart surgery.

Generally, when performing heart surgery on infants and children, a surgeon makes a vertical incision, running from just below the base of the neck to the mid-stomach.

But, for the last six months or so, Dr. Davis has been using a horizontal incision made in the body's natural crease below the breasts.

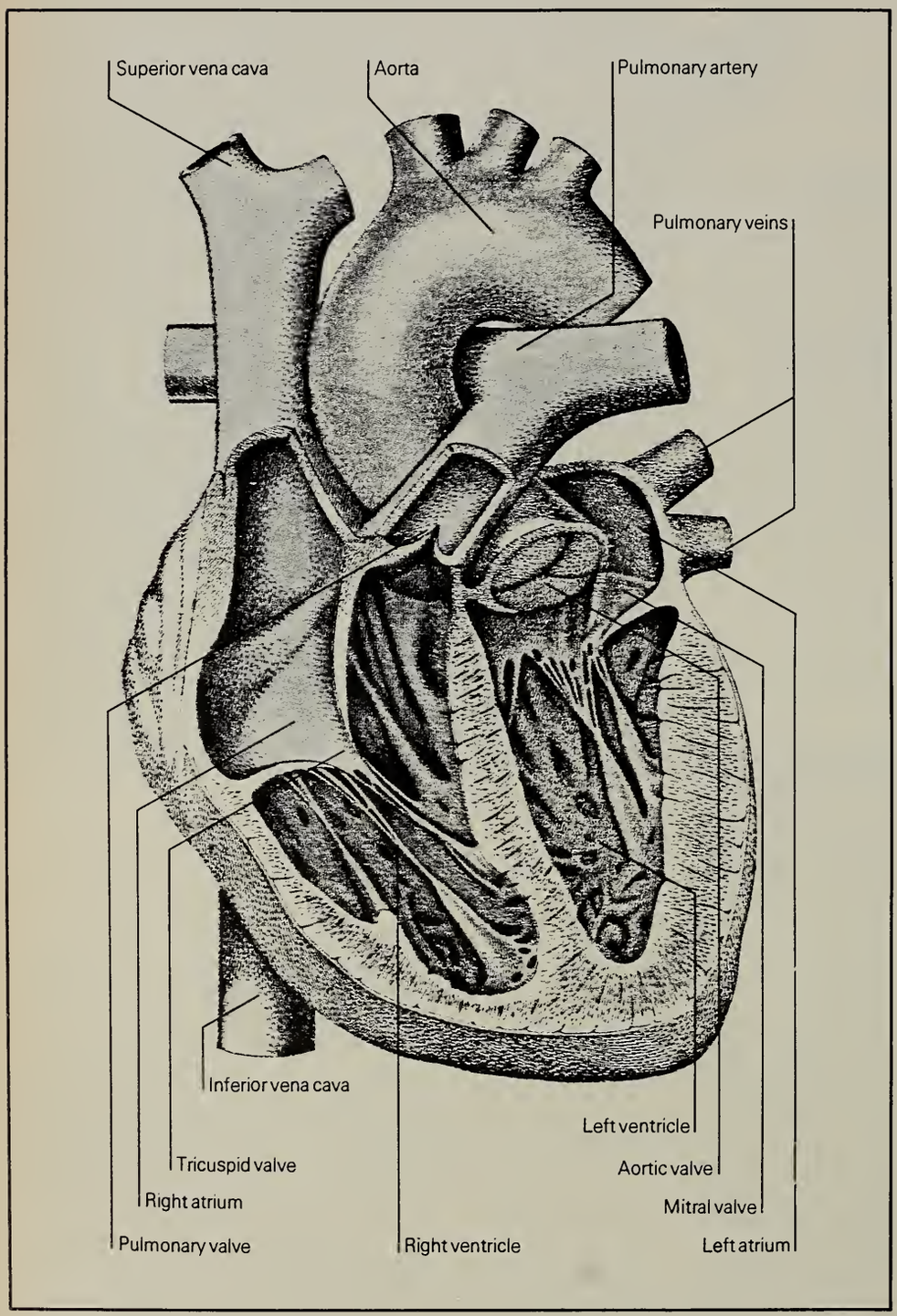
This "bilateral submammary incision" gives Dr. Davis easy access to the heart; and, like the "bikini incision," leaves a scar that can be easily camouflaged.

For this reason, the technique has important aesthetic and psychological benefits, Dr. Davis says. During adolescence, when body image is very important, a highly visible scar can lead to avoidance of locker rooms, swimming pools, etc., and may hinder social development, Dr. Davis points out.

Dr. Davis performs approximately 150 heart procedures per year to correct heart problems in children.

Although it's too early to conduct any long-term follow-up on the technique, the results thus far are encouraging, Dr. Davis says. — *Deborah Athy*

Ohio medi-scene . . . continued



The heart-brain connection

Are heart attacks caused by an imbalance in brain chemistry?

The heart-brain connection and how the two interact have become the newest, "hottest" topic these days in both cardiology and neurology.

But how new is it?

According to Charles Wooley, MD, a cardiologist and professor of medicine at Ohio State University, the subject has been around since at least the 1830s, and even earlier.

In a talk before the Joint Township District Memorial Hospital staff in Celina, Dr. Wooley pointed out that an English family physician by the name of John Calthrop Williams made the earliest attempts in this direction. He tried to differentiate between those patients with complaints of lightheadedness and dizziness (in other words, those experiencing palpitations) from those patients with organic heart disease.

Such efforts were continued by British physicians who cared for the army troops stationed in India during the 1860s, Dr. Wooley explains. There, young men in their twenties were being excused from duties due to similar types of symptoms. Doctors named the condition "irritable heart," and pointed to everything from India's hot climate to the soldiers' heavy packs and difficult close-order drills as the cause. Irritable heart was different from organic heart disease — the physicians knew it, but the heart-brain link still had to be made.

Even today, physicians are searching for answers.

The Cleveland Clinic recently established a Heart-Brain research program involving more than three dozen physicians and scientists from numerous disciplines, all seeking to make the connection.

"Many heart problems lead to brain problems and vice versa," says neurologist Anthony J. Furlan, MD, in an article which appeared in the Clinic's publication, *Challenger.*

"We are seeking to uncover the roots of these diseases which, in many ways, remain a mystery," he adds.

The program, in fact, is seeking to uncover answers to three separate questions: 1.) How does the brain control the cardiovascular system; 2.) What effect does heart surgery have on blood flow and metabolism in the brain; and 3.) What is the best therapy for treating acute stroke?

In searching for the heart-brain connection, the Cleveland physicians are putting to use medicine's most sophisticated techniques and technology. They are already mapping the brain circuits and chemicals involved in blood pressure control, and are testing the drugs being used to treat acute stroke.

"Since the mid-1970s, we have been . . . attempting to trace cardiovascular disease back to its roots, to what we believe are its origins at the level of the cell," says Carlos Ferrario, chairman of the Department of Cardiovascular Research, in the same article. "With the help of molecular biology, hypertension research now has moved to the cellular level."

For example, researchers involved in hypertension studies are now examining brain regions thought to regulate the cardiovascular system. A chemical imbalance in these regions may disrupt the normal cell-to-cell communication needed to keep blood pressure at normal levels, says Dr. Ferrario.

But even with the latest techniques, mapping regions of the brain, determining the nature of the brain's chemical messengers, and discovering how these messages affect the cardiovascular system is a formidable task.

"Cardiovascular control involves at least five brain areas that communicate with each other and the rest of the body," explains Dr. Ferrario. To date, their research has revealed what, in essence, are some of the major cities and roads in these areas, as well as where important products are made or stored. But more research will be needed to determine the chemical traffic — what it is, where it's going and how it influences blood pressure control.

Because so much is still unknown about the brain, however, researchers find they must approach their complex subject in simplistic terms — asking questions, for example, that will specifically yield "yes" and "no" answers. But even these simple answers build toward a greater understanding.

Determining the underlying cause of hypertension is not the only heart-brain connection being sought by the Cleveland team, however.

Researchers are also involved in finding improved ways to treat and prevent heart attack and stroke.

By using a technique known as quantitative double-label autoradiography along with a computerized imaging device which analyzes images of the brain, researchers can tell what is happening in discrete areas of the brain, and may even be able to indicate where a stroke is likely to occur.

"We are doing very early clinical testing of a concept called stroke-stress testing," explains Dr. Furlan in the article. "If a reliable method can be developed, it will give us a quick and accurate profile of the patient's blood flow and metabolism. Physicians could use it to screen patients believed at high risk for stroke prior to open-heart surgery. Surgeons might use the profile to determine how best to monitor a patient during a bypass procedure."

The program is also attempting to make the heart-brain link with regard to acute stroke.

"About 20 percent of all strokes are due to a clot that formed because of heart disease," says John R. Little, MD, Department of Neurological Surgery, in the same article.

The other major cause of sudden strokes is hemorrhage, where a blood vessel damaged by hypertension or aneurysm begins to leak into and around the brain.

Participants in the Heart-Brain program are currently in the process of testing drugs which may be useful in treating cases of acute stroke by attempting to understand the chain of biochemical events that lead to brain cell death.

"We are looking for the key steps in the destructive process that, if modified chemically, may be slowed, stopped, or even reversed. Our goal is to limit the

(Continued on page 326)


MALPRACTICE

Malpractice. Is the Issue Heating Up in Ohio?

By Carol Wright Mullinax

Ohio physicians have a steadily increasing chance of being sued for medical malpractice and have responded to the current professional liability crisis by making fundamental changes in their practice behavior. Many physicians report they are performing more "defensive" medical procedures and have eliminated some riskier procedures to lessen their chances of being sued.

These findings are among the results of a recent survey of OSMA membership concerning the status of the malpractice situation in Ohio. The survey was conducted by mail in mid-February. In all, 1,948 physicians responded to the survey, roughly 10% of full dues-paying members of the OSMA, a statistically significant rate of survey participation.

In spite of increased tensions felt by physicians, however, the survey did show that most cases of alleged medical malpractice filed against doctors were being settled in the physician's favor, that most are settled out of court and for less than $10,000.

The survey found:

- Almost all respondents do carry medical professional liability insurance.
- About half have been sued for medical malpractice.
- Suits are on the increase.
- Most Ohio physicians pay $5,000 or less annually for medical professional liability coverage.

The OSMA conducted the survey at the request of the Strategy Subcommittee of the OSMA Task Force on Professional Liability to determine the extent of the problem in Ohio. Of the 1,948 physicians who responded to the survey, the vast majority were male (92.70%), with a fairly even breakdown by age. Most respondents, 53.72%, described themselves as being in a solo practice; 23.24% were in a single specialty partnership.

As far as specialty of practice was concerned, specialty categories were grouped in the survey according to professional liability risk groups.

Most respondents, 56.45%, fell into the first category which consisted of Family/General Practice, Internal Medicine, Pathology, Pediatrics, Psychiatry, Allergy, Dermatology, Occupational Medicine, Radiology (diagnostic only), and Ophthalmology (no surgery). For a complete breakdown of specialty categories and number of respondents, see Chart *one*.

Response Rate of Specialty Categories

Group One **56.45%**
Family/General Practice, Internal Medicine, Pathology, Pediatrics, Psychiatry, Allergy, Dermatology, Occupational Medicine, Radiology (diagnostic only), Ophthalmology (no surgery)

Group Two **8.85%**
Emergency, Ophthalmological surgery, Urology, Radiology with X-ray therapy

Group Three **14.43%**
Anesthesiology, ENT surgery, General surgery, Gyn surgery

Group Four **9.72%**
Ob-Gyn, Plastic surgery, Hand, head and neck surgery

Group Five **5.58%**
Cardiovascular surgery, Orthopedic surgery, Thoracic surgery, Vascular surgery, Neurosurgery

Group Six **4.96%**
Other, specified

Chart One

Virtually all (98.72%) of the respondents were covered by professional liability insurance, with 35.63% being claims-made and 64.37% being occurrence insurance. The majority, 72.23%, carried between $300,000 and $600,000 primary coverage; 64.91% carried $1 million excess coverage. Approximately one third, 32.95%, carried $1 million/$1 million single limit coverage. Most respondents (74.60%) are or will by the end of 1986 be required to carry a minimum of $1 million medical professional liability insurance.

According to the results of the survey, most Ohio physicians are not yet experiencing the dramatic professional liability premiums as have been seen in several other states. Nearly half of the respondents indicated that they pay $5,000 or less annually for coverage. The complete breakdown is as follows:

$0-5,000	50.30%
$5,001-10,000	15.61%
$10,001-15,000	10.01%
$15,001-20,000	9.91%
$20,001-25,000	5.49%
$25,001-30,000	2.72%
$30,001-40,000	1.28%
$40,001-50,000	.31%
$50,001-75,000	.26%
$75,001-AND UP	1.75%

In an effort to further analyze the premium costs, the OSMA asked respondents to report the amount of their gross annual income from their practice in 1985, and then compared these figures to the average amount spent annually on professional liability premiums. The amount, on the whole, was relatively low.

For example, 66.39% of those who reported an annual income of $50,000 or under paid $5,000 or less in professional liability premiums. In the income category of $50,000 to $75,000, 74.54% paid $5,000 or less. In the $75,000 to $100,000 category, 60.58% paid $5,000 or less; in the $100,000 to $150,000 range, 44.35% paid $5,000 or less; in the $150,000 to $200,000 range, 32.71% paid $5,000 or less; and in the $200,000 and up range, 24.48% paid $5,000 and less. For a complete breakdown, see Chart *two*.

However, the survey indicated that there was a direct correlation between premium paid and risk/specialty classification. As would be expected, physicians in higher risk/specialty categories paid higher annual premiums than those in lower-risk categories. For example, most physicians in Group Five (33.03%) paid $20,000-$25,000 annually in premiums. For more information, see Chart *three*.

Of the 1,948 physicians who responded to the survey, 46.98% indicated that they have been sued for malpractice. Of those physicians sued, 55.70% have been sued only one time; 25.11% have been sued twice; 10.53%, three times; 4.50%, four times; and 4.17%, five or more times.

A physician's chance of being sued increased significantly according to his or her risk/specialty classification. In Specialty Group One, 36.62% of the physicians reported having been sued; in Group Two, 50.28%; Group Three, 58.15%; Group Four, 68.42%; Group Five, 74.31%. Group Six is a catch-all category with a positive response rate of 39.17%.

A breakdown of when the suits were initiated shows that there has been a steady increase in the number of suits filed in Ohio since 1981. Respondents were asked to indicate the year in which malpractice suits were initiated against them.

1970 to 1975	— 19.81%
1975 to 1980	— 18.61%
1981	— 6.96%
1982	— 8.99%
1983	— 11.21%
1984	— 14.49%
1985	— 17.39%
1986	— 2.83% (as of mid-February) (24% if projected for 1986)

To help pinpoint the most common grounds for a malpractice suit, the OSMA asked respondents to select one of nine categories for the last suit initiated against them. Of those answering the question, the most common responses were as follows:

Bad result	23.60%
Failure to diagnose	19.97%
Other, specified problems	14.47%

Most often (70.23%), physician respondents were named along with hospital and other physicians in the suits.

Of the total respondents, 23.79% reported that they still have a suit pending against them. Of those with a suit pending, 71.94% have one suit pending, 24.22% have two suits, and 2.88% have three suits pending.

Of the respondents who reported on the final disposition of the most recent action against them, 32.08% settled out-of-court without payment, 49.93% settled out-of-court with payment, 13.55% went to court and won, and 4.42% went to court and lost. These figures illustrate the fact that a large number of frivolous suits are filed, with nearly 46% of the suits either being settled without payment or won in court. The large number of suits settled with payment may indicate, as many physicians stated in the comment section of the survey, that there is a tremendous pressure to settle cases out-of-court — frivolous or not.

As to the awards granted as a result of the suits, in the majority of cases, regardless of how the suit was resolved, the settlement was under $10,000. Of the suits settled out-of-court with payment, the breakdown is as follows:

Settlement of 0 to $10,000	46.19%
$10,000 to $25,000	17.01%
$25,000 to $50,000	9.39%
$50,000 to $100,000	12.44%
$100,000 to $500,000	13.71%
$500,000 to $1 million	0%
over $1 million	1.27%

Awards determined by juries were in the same approximate range:

Settlement of 0 to $10,000	50.85%
$10,000 to $25,000	13.56%
$25,000 to $50,000	11.86%
$50,000 to $100,000	11.86%
$100,000 to $500,000	10.17%

Income Compared to Annual Premium

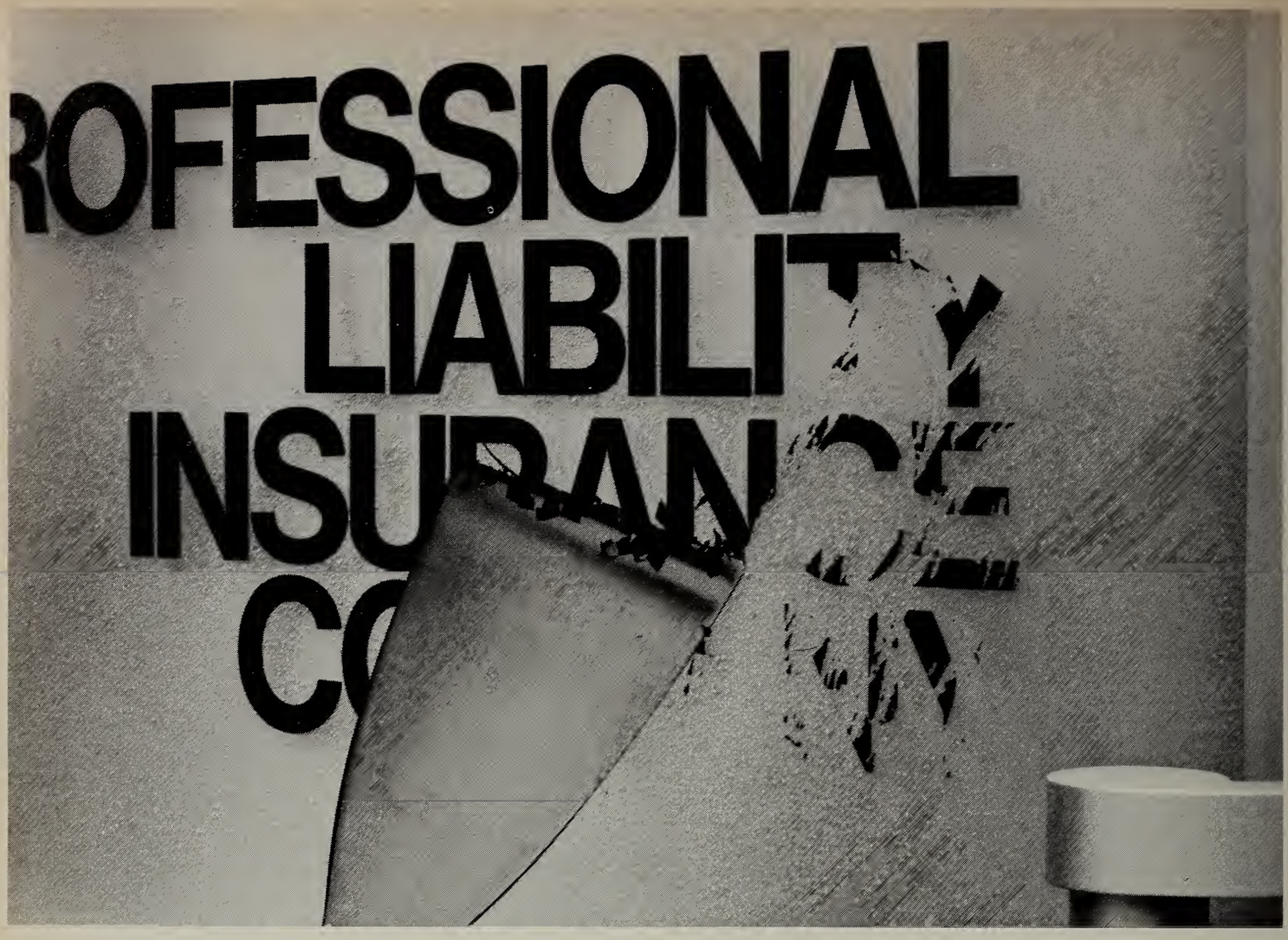
Income	Amount of Premium: 0-$5,000	$5,000 to $10,000	$10,000 to $15,000	$15,000 to $20,000	$20,000 to $25,000	$25,000 to $30,000	$30,000 to $40,000	$40,000 to $50,000	$50,000 to $75,000	$75,000 and up
$50,000 and under	66.39%	10.08%	3.78%	2.52%	1.26%	0%	.84%	0%	.42%	1.68%
$50,000 to $75,000	74.54%	11.62%	3.73%	2.49%	2.49%	.83%	.41%	0%	.41%	1.66%
$75,000 to $100,000	60.58%	16.52%	7.83%	4.06%	4.06%	.58%	1.16%	0%	0%	1.45%
$100,000 to $150,000	44.35%	15.00%	13.70%	13.48%	5.22%	2.17%	.65%	.43%	.22%	2.17%
$150,000 to $200,000	32.71%	18.80%	14.29%	13.91%	7.14%	6.39%	2.63%	1.13%	.75%	1.13%
$200,000 and up	24.48%	21.49%	13.43%	18.21%	11.34%	5.97%	2.39%	.30%	0%	1.79%

Chart Two

Comparison of Specialty Group to Annual Premium

Specialty	Amount of Premium: 0 to $5,000	$5,000 to $10,000	$10,000 to $15,000	$15,000 to $20,000	$20,000 to $25,000	$25,000 to $30,000	$30,000 to $40,000	$40,000 to $50,000	$50,000 to $75,000	$75,000 and up
Group One	74.70%	14.34%	2.19%	1.00%	.09%	.27%	.55%	0%	.27%	1.92%
Group Two	16.18%	52.02%	15.61%	6.36%	1.16%	.58%	.58%	.58%	0%	1.73%
Group Three	3.23%	11.83%	35.84%	27.96%	7.53%	6.45%	1.08%	1.08%	.36%	1.08%
Group Four	5.35%	8.02%	11.76%	37.43%	23.53%	6.42%	3.74%	.53%	.53%	1.07%
Group Five	3.67%	2.75%	11.01%	20.18%	33.03%	17.43%	5.50%	.92%	0%	2.75%
Group Six	64.95%	11.34%	13.40%	1.03%	2.06%	0%	2.06%	0%	0%	1.03%

Chart Three



In ten years your malpractice carrier may be just a memory.

Unless it's Medical Protective.

As you consider professional liability insurance, consider this. The coverages stated in the policy are basically a promise — a promise to be here when needed regardless of legal climate or economic conditions. A company's ability to keep this promise is critical because your financial security may depend on it. Unfortunately, too many firms are now finding the task impossible.

Analyze your liability insurance options carefully just as you would any important investment. Go beyond the agent and the policy to the company that stands behind both. How long has it been in operation? Has it weathered some of the tough times? Will it be there for you when you need help?

The Medical Protective Company pioneered professional liability coverage before the turn of the century and has served doctors exclusively ever since. Over 500,000 of them. Through good times and bad. We'll be here when you need us.

Contact The Medical Protective Company through one of our general agents. History shows we keep our promises.

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1011 Sandusky Street, Perrysburg, OH 43551, (419) 874-8080

Stuart Mitchelson, Robert Dowdy, Suite 111, 1 Commerce Park Square
23200 Chagrin Blvd., Beachwood, OH 44122, (216) 464-9950

$500,000 to $1 million	1.69%
over $1 million	0%

Awards determined by judges fell into the following range:

Settlement of 0 to $10,000	38.30%
$10,000 to $25,000	34.04%
$25,000 to $50,000	10.64%
$50,000 to $100,000	6.38%
$100,000 to $500,000	8.51%
$500,000 to $1 million	0%
over $1 million	2.13%

Most respondents reported some type of impact on their practice of medicine as a result of concern over professional liability. Most commonly reported effects were: increased procedures and defensive medicine (24.27%); elimination of riskier procedures or practices (17.77%); and increased average medical fees (18.43%). Estimates of how much fees have been raised ranged from 2% to 40%.

One answer which was not included with this question but which was listed by a large number of respondents was the decision to switch to salaried positions from regular fee-for-service medicine. Another common response in the "other" category was increased anxiety or stress.

It is distressing to note that 12.5% of the respondents (245 physicians) indicated that they are considering closing or have closed their practices as the result of concern over professional liability.

Perhaps most revealing as to the state of professional liability in Ohio were the comments of the respondents at the end of the survey. Comments generally fell into one of two categories: descriptions of how concern over professional liability has affected the practice of medicine and solutions to the problem.

- "The adversarial attitude of patients makes the practice of medicine *very* uncomfortable. I feel that the personal stress will shorten my life. It is tough to keep the practice of medicine FUN anymore. Traditional medicine? R.I.P."
- "It is scary to practice in this environment."
- "I have been overtrained as a Family Practitioner to do what I can comfortably do in the present setting of litigious life."
- "I actively discourage anyone who is considering medicine as a career. I regret my decision to make medicine a career, even though I enjoy the academic and personal challenges. At age 38 when I should be 'in my prime' as a physician, I find myself anxiously awaiting the day I can quit."
- "This crisis has produced a subtle change which positions many patients in an adversarial role. This change took away much of the joy I used to feel when practicing my skills. When an opportunity to move into administration was offered, I took it. Unfortunately, the upcoming generations of patients will never know what they have lost."
- "I have begun to feel that every time I'm called out to the emergency room, I risk every asset my family and I have acquired. I see every patient as a possible 'instant millionaire' after my insurance."

Although definitely in the minority, several physicians pointed out the other side of the coin:

- "We bitch too much. Pay bills and take care of people. Add to your cost of doing business."
- "I definitely think that many more physicians are now giving their patients' safety a higher priority. Many unnecessary surgeries are avoided. The malpractice crisis has had its good side too."

As to possible solutions, many respondents pointed to some type of tort reform. As one physician put it: "Unless tort laws are corrected, medicine as we know it will be sued out of existence. There goes a dinosaur — a physician."

Specifically mentioned as a solution in many surveys was a limit on contingency fees:

- "One lawyer who gets 40% of a $2 million settlement adds more cost to the health care system than the gross collections of five average doctors working all year. If Congress is truly interested in limiting the cost of health care in this country, they could do more in one fell swoop by severely limiting lawyers' fees than in squeezing the doctors on nickel and dime day-to-day fees."

Lawyers, in general, were the topic of many solutions:

- "Do not elect lawyers."
- "Close ⅞ of the US law schools."
- "For every Toyota from Japan, send them back one US attorney."

Definitely in the minority, but also mentioned as solutions, were increased emphasis on cleaning up the medical profession and on a restructuring of insurance premiums to make physicians who are sued more often bear more of the financial burden.

Finally, a few respondents mentioned a strike as one possible solution. As one physician put it: "We need Jimmy Hoffa." **OSMA**

Carol Wright Mullinax is the Director of OSMA's Department of Communications.

ANGER

Dangerous Enemy, Powerful Ally

By Francine Rasco, MD

Her stylish clothes hang loosely on the painfully thin young woman sitting across from me. She has lost 16 pounds, which she thinks is due to her gastric ulcer. Her family practitioner has referred her to me for psychiatric consultation and treatment after trying all the standard interventions with only minimal improvement. She finally asked the patient in a kind, caring way if she were having problems at home or work. The patient became tearful and admitted that she had recently learned her husband was having an affair with another woman.

In her first psychotherapy sessions, the patient tells me of her distressing marital situation while wearing an inappropriate, little smile. My approach in the therapy focuses on improving her awareness of the hurt and anger behind that constant smile and, then, on her conflict over the healthy expression of anger. Soon, the inappropriate smile disappears. She becomes more assertive at home and at work, and her ulcer heals.

This case demonstrates only one of the many ways in which people suffer physically, as well as emotionally, from unhealthy expressions of anger. Some other ways include strokes, myocardial infarctions, headaches, possibly cancer, bulimia, chemical abuse, depression, suicide, homicide, and spouse and child abuse. More often than not, the general or family practitioner is the first professional to be consulted regarding these unhealthy effects. Therefore, the physician needs a high index of suspicion to detect the emotions underlying health and behavioral problems in order to treat the patient effectively and to know when to refer for psychiatric consultation.

Why is anger such a problem for civilized human beings? Emotions in general can seem overwhelming to some degree because they are involuntary conditions which override our conscious intentions. They are



Once aroused, the physical reactions to anger take some time to subside.

Anger . . . *continued*

involuntary because they are rooted in the biochemistry of the body, e.g., the sympathetic nervous system and the powerful hormones that do its bidding. As you know, when one is angry, the changes wrought by these hormones prepare the body to fight. Once aroused, the physical reactions to anger take some time to subside, especially if the individual is unable to engage in strenuous physical activity for which the body is now prepared. We speculate that the physical and emotional problems mentioned above can be directly and indirectly caused or exacerbated by denying the body the activity it craves when this complex neurologic and hormonal mechanism roars into gear.

However, large-muscle activity is but one way of dealing with anger. Assertive verbal expression and creative channels can also be healthy, effective outlets. Unfortunately, several psychological attitudes can block the awareness and healthy expression of anger.

Many of my patients have developed a sense of helplessness, especially in dealing with anger, by growing up in households where any kind of self-assertion was frowned upon, and a cross word or momentary loss of temper was regarded as a crime. Children need adults to accept their anger and to help them express it in socially acceptable ways. They also need to see adults express their own anger and aggression honestly and constructively or, at least, nondestructively. Otherwise, they grow up feeling incompetent to deal effectively with anger in themselves and in others.

Guilt is another result of a parental and societal attitude that considers it morally wrong to feel or express anger. Children afflicted by such an attitude can become adults who feel like bad people whenever their anger tries to raise its head. Then they may unknowingly direct it toward themselves in the form of depression, thereby providing the anger with an outlet but simultaneously punishing themselves for having such an "unacceptable" feeling in the first place. It is no accident that depression so often accompanies the physical illnesses stemming from suppressed rage.

Too frequently, depression leads to suicide, the ultimate punishment for one's unacceptable feelings. Suicide also frequently represents a vengeful attack upon friends and family, who, the perpetrator believes, would never accept a healthier expression of anger. Unfortunately, sometimes depressed people are right about this. In family therapy with the depressed we often have to work on developing greater tolerance for anger on the part of every member of the family, including the identified patient.

Bulimia represents yet another possible effect of this suppression. Unfortunately it is no longer an unusual problem, as shown by the alarming increase in the prevalence of bulimia in America and other industrial nations, especially among young adult women. After much reflection and self-observation, my bulimic patients tell me that they gorge when they feel angry, as well as some other emotions. This confirms the findings of some psychoanalysts, who maintain that bulimics express their anger by devouring huge quantities of food, then symbolically purge themselves of their rage with vomiting and laxatives.

Physical problems, depression, suicide and bulimia represent some ways in which anger can be turned primarily on one's self, but, of course, anger can be turned directly on others in the forms of verbal and physical abuse. One is the most vulnerable to such assault within one's own home. Although no one knows the true extent of violence within families, we do know that one-fourth of American murders are family affairs and that half of these are spouse killings. Furthermore, wife beating, the most common form of violence committed against women, is also the most common signal of worse to come. Estimates regarding child abuse vary, but it could be that two million children 7 years of age and younger are physically abused each year (not including sexual abuse). Here again, the pediatrician and the family practitioner may be the first professionals to be presented with the effects of such abuse. Besides taking the necessary steps to protect those in danger of abuse, we should also be prepared to refer both the victim and the abuser for psychological help. Remember that the effects of abuse are mental as well as physical and that the abuser suffers, too, although indirectly. Usually, the abuser was also abused as a child or suffered the psychological trauma of watching

Suppressed anger can lead to illness, helplessness, depression and violence.

a father attack a mother.

What happens when the doctor is angry? Healthy outlets abound, including improved assertiveness, sports, gardening, and discussion with family, friends and colleagues, to mention only a few. However, physicians often have less time than their patients for the healthier outlets and, being human, we share the same risks as our patients if we fail to recognize our anger and deal with it constructively. Furthermore, our patients, families and co-workers can suffer from our poorly expressed anger. Much has already been said, although never enough, about the physicians who abuse addictive chemicals, and I suspect that some do so to suppress anger about the many stresses and frustrations encountered in our work. But what about unhealthy expressions of anger that are more subtle? Which of us can honestly say that we have never snapped at a family member or co-worker, who did not deserve our irritation but merely represented an easy target? Few, I'm sure. Subtler still are the lack of empathy and even neglect suffered by patients when the physician is angry. We have the same personal responsibility as our patients, and certainly a professional responsibility, to recognize our emotions and deal with them constructively, whether by allowing time to smack a tennis ball until the anger dissipates or seeking psychiatric or psychological consultation for ourselves when we cannot otherwise resolve the anger.

Emotions demand expression, biologically and psychologically. Suppressed anger can lead to illness, a sense of helplessness, depression and violence. To avoid these hazards we must help our patients, our families and ourselves to recognize anger and to discuss it. If one lacks the skills or the patience to verbalize sudden anger constructively right then, one can expend the associated increased physical energy through sports, digging in the garden, strenuous housework or even just running up and down some stairs. Those who persistently have trouble recognizing their anger and expressing it constructively need psychiatric consultation and treatment.

We must recognize that we are not god-like but human, that we are biological, psychological, social and spiritual beings. No other creatures that we know of are so complex. Dealing constructively with such complexity provides us with our greatest challenge as human beings and also provides us, when we succeed, with our greatest triumphs.

Dr. Rasco is a psychiatrist in private practice in Worthington and director of an inpatient unit and vice president of the Medical Staff at Harding Hospital.





Agency Reference

To find the PICO agent(s) in your area, consult the listing below.

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Youngstown, Ohio 44507
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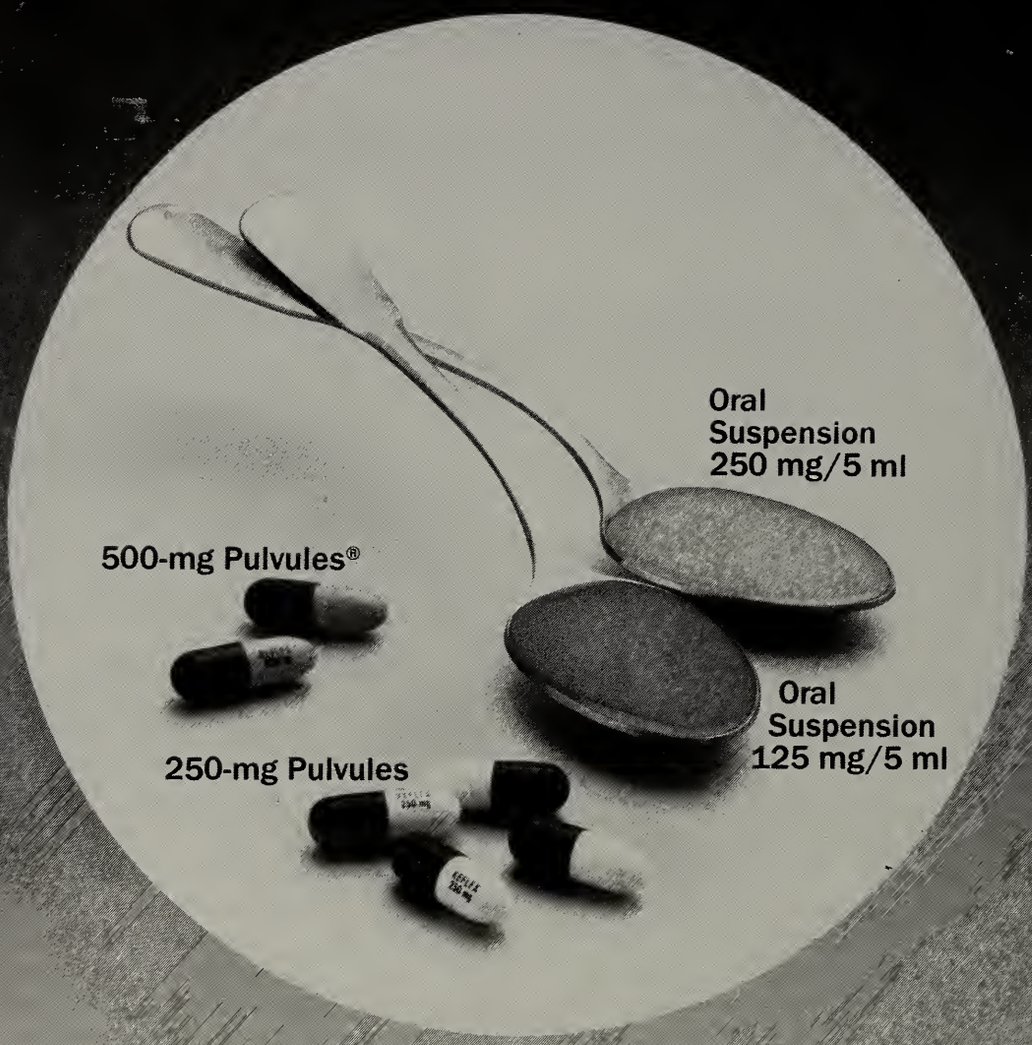
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Doctor: Are You Being Duped?

Beware! Some substance abusers are counting on you . . .

By Carol Wright Mullinax

No one likes to be tricked. But "duped" providers were one of four categories of health care professionals identified by the Prescription Abuse Data Synthesis Project who are responsible for putting legal prescription drugs into the hands of people who misuse them.

The PADS program, funded by the AMA and sponsored by the OSMA (see OSMA Journal, January 1986), was designed to identify and eliminate sources of prescription drug diversion in the state.

Along with duped health care providers, PADS also identified three other categories of providers who dispense drugs improperly:

Dated — Providers who have not kept pace with developments in pharmacology, drug therapy or abuse of drugs;

Disabled — Providers whose professional competence has been impaired by drug abuse, alcoholism or other physical or mental disorders;

Dishonest — Providers who knowingly and willingly prescribe and/or dispense drugs for purposes of abuse.

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"A request for positive identification and/or a telephone call or two can be an effective deterrent."

Are You Being Duped? . . . *continued*

Below are some of the more common scams used to dupe physicians into misprescribing drugs.

"Fat Lady" Scam

A popular deception is the so-called "fat lady" scam, perpetuated by an itinerant team of four or five badly overweight women and one man. Their carefully devised plan involves moving to a new community, and developing a schedule which allows each female member to visit a maximum number of physicians each day for a week or so.

The "scam" is (with variations) that the patient is very unhappy, due to her weight problem. Her husband is about to leave her, her children are embarrassed, and she professes to be weak and unable to maintain any diet regimen. In desperation ("she has considered suicide"), she wants to discuss the possibility of having her jaws wired shut or having part of her intestines removed. The interview usually is tearful and well delivered, and often moves into consideration of medication, as an alternative. The stimulant drugs which are obtained are sold to "street dealers" by the male member of the team. Weekly profits, from the numerous prescriptions gained, have been estimated to be a high as $10,000.

"Grandpa" Scam

The so-called "grandpa" scam involves what appears to be an innocent young girl and her supposedly terminally ill ("stomach cancer") grandfather, who are en route from Alabama (or some other place) to Oregon (or some other place), so that grandpa can be with kinfolks when he "passes."

The old man willingly shows his scarred abdomen and explains that he had surgery at a V.A. (or other public) hospital. He further explains that he is allergic to certain pain remedies. The conversation usually comes around to Preludin or Dilaudid — which the old man agrees has been used before with good results.

After obtaining the prescription, usually an inordinately large amount ("he's a long way from Oregon"), the couple sell the drugs to local street dealers, usually for $15 to $20 per unit dose. The pair are reported to frequently net as much as $5,000 per week. They normally will remain in one community for two weeks.

"Hyperactive Child" Scam

Authorities in Western Missouri have reported a new scam. Parents (at least adults) have trained young children to convincingly demonstrate symptoms which are usually associated with hyperactivity hyperkinesia.

The objective of this scam is to deceive physicians and to improperly gain prescriptions for *Ritalin.*

"Blood in the Urine" Scam

An occasional ruse used by experienced male professional patients is the *blood in the urine scam.* As part of the technique in scams where a specimen might be required, a pin or needle is concealed in the clothing. These clever professional patients then can easily add blood to the urine by simply pricking a fingertip or scratching the interior of the urethra. The presence of blood in the specimen makes the scam all the more convincing.

In all of the above-mentioned cases physicians are cautioned to be wary of patients who: (a) are unknown to them; (b) demonstrate behavior normally associated with drug abusers; (c) have insufficient identification; or, (d) otherwise appear suspicious. A request for positive identification and/or a telephone call or two can be an effective deterrent to such scams.

"Girlfriend in the Office" Scam

Prescribers need to be alert to a frequently employed indirect professional patient scam. In such instances, a drug abuser/dealer will cultivate a social relationship with a member of the office staff (receptionist, secretary, nurse, assistant, etc.) in order to gain access to prescription pads, drugs, forged signatures or even telephone prescriptions. Such techniques are possible when office personnel are minimally supervised. In such arrangements the professional patient has a built-in bonus. The office accomplice is frequently able to intercept calls from pharmacists attempting to verify questionable prescriptions.

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"Prescribers are cautioned . . . to use ink or indelible pencil; write out actual amount of medication prescribed and never leave prescription pads unattended."

Are You Being Duped? . . . *continued*

Prescribers can minimize the possibility of unethical/dishonest staff behaviors by: maintaining good office discipline; tightly controlling prescription pads; communicating directly with dispensers; and being sensitive to the demands of the "street market."

The "Police Report" Scam

Kansas City investigators have recently uncovered a new twist to professional patient approaches to physicians and dentists. Following any successful attempt at securing desired prescriptions, a return visit is made within a few days.

The professional patient explains to the prescriber that shortly after his last visit, he was robbed (or burglarized) and his medication was taken. He then shows the physician/dentist evidence that he has reported the incident to the police. He usually exhibits a copy of the police report. Obviously he needs a replacement prescription.

This ploy is apparently very successful. The professional patient has doubled the amount of drugs illegally secured by his original scam.

Physicians and dentists are cautioned to be alert in such occurrences. Changing the replacement prescription to an alternative drug — one not so highly valued by the professional patient — can be an effective deterrent to this use.

"The Altered Script" Scam

Prescribers who short-cut proper prescription writing practice, especially those who use arabic numerals for dose amounts (not reinforced by a written number), are easy marks for professional patients. By simply matching the ink color of the prescribers pen or ball-point, a prescription for 10 can become a prescription for 40; 5 can become 25. A prudent prescription becomes excessive, and proportionally more profitable to the professional patient.

Prescribers are cautioned to always follow good prescription writing practice; use ink or indelible pencil; write out actual amount of medication prescribed in addition to Arabic or Roman numerals, *and* never leave prescription pads unattended.

"The Detailman" Scam

There have been instances where clever scams have been perpetrated on unwary professionals by detailmen (salesmen). A common scenario is: unwanted drugs are added to orders being placed by pharmacists or dispensing professionals — usually after the order is signed and when the detailman is away from the store or office. The over-ordered pharmaceuticals are invariably for the high priced "street" drugs. (Dilaudid, for example, sells on the streets for $50 a tablet.)

When the order arrives at the pharmacy or doctor's office, and when the "mistake" is discovered, it is customary for the complaint to go directly to the detailman. After perfuse apologies ("I don't know what's wrong with those people in shipping!"), the detailman explains the procedure used in such cases. He directs the practitioner to pay the full invoice and assures that he (the detailman) will stop by in a day or two to pick up the unwanted drugs, which will be returned to the supplier. Of course, the mistake will be compensated with his personal check.

"Street" drugs in wholesale amounts (usually of 500/1000) are now available in resale to the addict market.

Pharmacists, dispensing practitioners and hospitals are cautioned to be alert for any suspicious irregularity in ordering procedures.

Physicians who recognize or uncover drug scams in their own practices are asked to report them to Carol Mullinax, Communications Director, OSMA, 600 South High St., Columbus, Ohio 43215. These reports will be shared with *Journal* readers as well as physicians in other states.

This education effort is one of a wide variety of solutions to the drug diversion problem recommended by the PADS report. Further developments will be covered in future editions of the *Journal.* **OSMA**

Carol Wright Mullinax is the Director of the OSMA Department of Communications.

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Ohio medi-scene

The heart-brain connection

continued

amount of brain tissue affected by a stroke and, if possible, to restore function," says Dr. Little.

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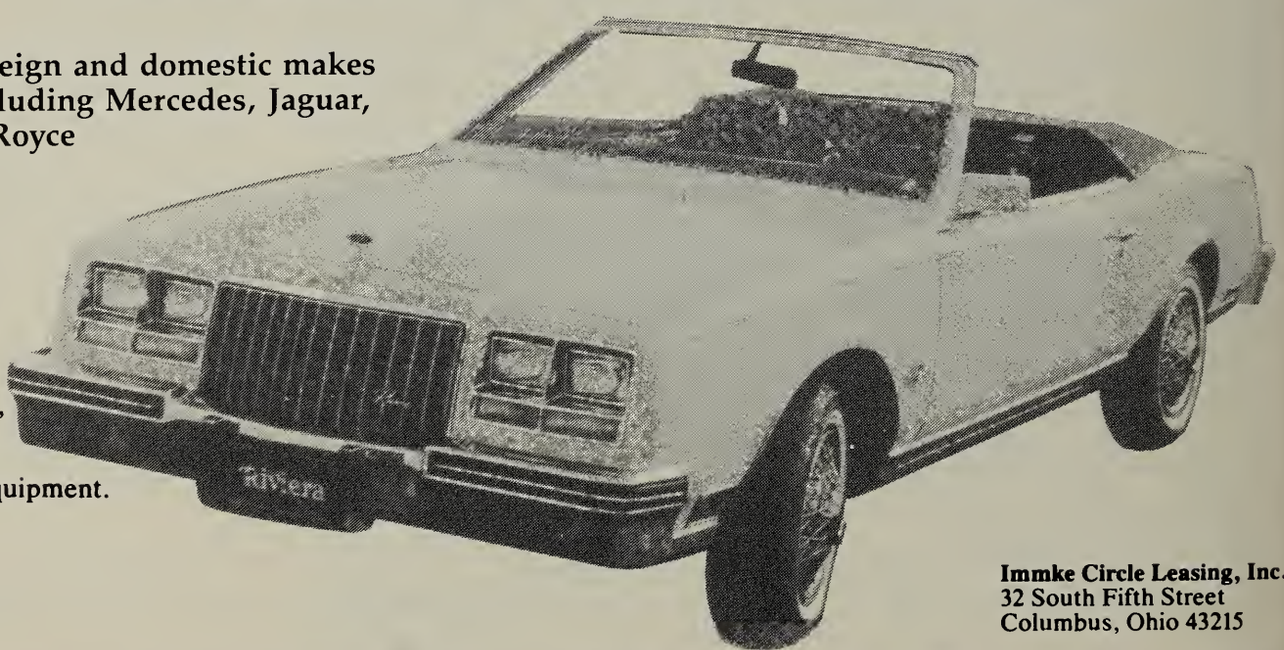
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Councilor Commentary

Fourth District

John A. Devany, MD

When John A. Devany, MD, a Toledo otolaryngologist, says, "An Irishman can't stay out of politics," he's speaking from firsthand experience. But over the years, that's not the only element that has kept him intrigued by the political side of medicine.

Dr. Devany's introduction to organized medicine — specifically, the OSMA — took place as far back as 1954, while he was a medical student at the Ohio State University. "My first dealing with the OSMA, and the first time I met Hart Page, was when I went to Chicago as a member of the Student American Medical Association," he recalls. And since that time, his interest and involvement in organized medicine has never waivered.

Looking back, it seems that a career in medicine was a natural choice. "First of all, my father was a family practitioner," he says. "And in my family, it seems you had to be a doctor or a lawyer or a priest. I wasn't suited to be a lawyer or a priest," he jokes; then he sums up the real reason he decided to make medicine his lifelong vocation like this: "I love the profession."

As far as his involvement in organized medicine, he says, "My classmates might have said that I didn't know how to keep my mouth shut — but I wanted to have a voice in the direction medicine was heading," he says.

After receiving his MD degree from the Ohio State University in 1955, Dr. Devany went on to complete an internship at Akron's City Hospital. He was leaning toward pediatrics as his specialization, but, after a stint in the Air Force as a flight surgeon and hospital commander, he found himself drawn to otolaryngology, a field that was really "entering its renaissance."

Dr. Devany decided to devote himself to this field, and he completed his residency at the Henry Ford Hospital in Detroit, Michigan in 1959-1962.

But Dr. Devany's initial interest in pediatrics never fell to the wayside; and, today, his ear, nose and throat practice is heavily oriented toward children. He is currently one of four physicians in the Toledo Otolaryngologist Group, Inc., and is on the active staff of St. Vincent and Toledo Hospitals.

Throughout his career, Dr. Devany has been involved in organized medicine at all levels: as president of the Northwestern Ohio Health Planning Company; president of the Academy of Medicine of Toledo and Lucas County; delegate to the OSMA; member of the American Academy of Opthalmology and Otolaryngology, the American Council on Otolaryngology, and the Academy of Medicine of Toledo and Lucas County, as well as a number of other committees and organizations.

In his current role as 4th District Councilor, Dr. Devany represents physicians "in an interesting combination of practices" from 10 counties in Ohio, including Defiance, Fulton, Henry, Lucas, Ottawa, Paulding, Putnam, Sandusky, Williams and Wood. The 4th District is a conglomerate of both rural and metropolitan areas, Dr. Devany says. One of those metropolitan areas is Toledo, which is "the hub of the district," he says, "with nine hospitals and virtually every



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type of specialty represented there." But many of the outlying areas are smaller and more rural, and, although many have "well-delineated superstructures," the majority have populations of 20,000 or less.

Since his election in 1985, Dr. Devany has found that simultaneously representing the rural and metropolitan physician isn't really much of a problem. First and foremost, he points out, "We are physicians. When it comes down to it, there are more areas of agreement among us than disagreements.

"We communicate remarkably well with both the rural and metropolitan areas," he continues. Still, this compatibility didn't develop out of thin air. Dr. Devany has made it a point to investigate the medical field from the local perspective as well as from the hub of District Four. He accomplished this, in part, by making periodic visits to the Fulton City Health Center in Massillon. "It gave me an opportunity to meet people on their home territory, and it also broadened my perspective," he says. He admits that sometimes it takes a little time to get news rolling, but, eventually, the word does get around.

For example, Dr. Devany is aware that some physicians in his district are concerned about the possibility of "decreasing occupancy in rural hospitals because of government and third party intervention such as the implementation of DRGs." And, in addition, he realizes that a great majority of metropolitan physicians are showing concern about the influx of alternative delivery systems.

"Everyone is concerned about them (alternate delivery systems) . . . to the point that some are running scared," he says. There are nine HMOs currently getting started in the district, he says. Like other parts of the state, "the area is ripe to be plucked."

Dr. Devany says some doctors join because they don't want to lose their patient base. "They are more or less confused about how to protect their marketplace," he points out. This is especially true for the specialist who depends on referrals from the general practitioner. If the general practitioner joins an HMO and begins to refer patients to an HMO specialist, the private specialist will be left out in the cold, he explains.

So, while Dr. Devany does foresee a "shake up" in the medical world, he doesn't anticipate the end of private practice. "I don't think the death knoll has sounded for the private practitioner," he says. When all is said and done: "The word gets out who the excellent doctor is."

And, as far as organized medicine is concerned, both the HMO physician and the private physician should be equally represented. "We cannot take a limited stand; we must represent everyone. The day the OSMA can be a voice for the private practitioner alone is gone," Dr. Devany says.

After all, "that is one of the challenges of organized medicine: To represent physicians in a broad sense, instead of in the narrow, local sense some hospitals encourage," he continues.

"We must transcend problems such as competition and concerns about the alternative ways of delivering health care so that we can deal with a whole spectrum of other, more immediate problems that must be addressed with a unified voice," Dr. Devany points out. "We must never lose sight of the fact that, as physicians, no one can address the issues facing us like we can." — *Deborah Athy*



John A. Devany, MD

Deborah Athy is Information Specialist and Editorial Assistant for the Journal.

THE BEST TAX SHELTER

By James L. Budros, CFP

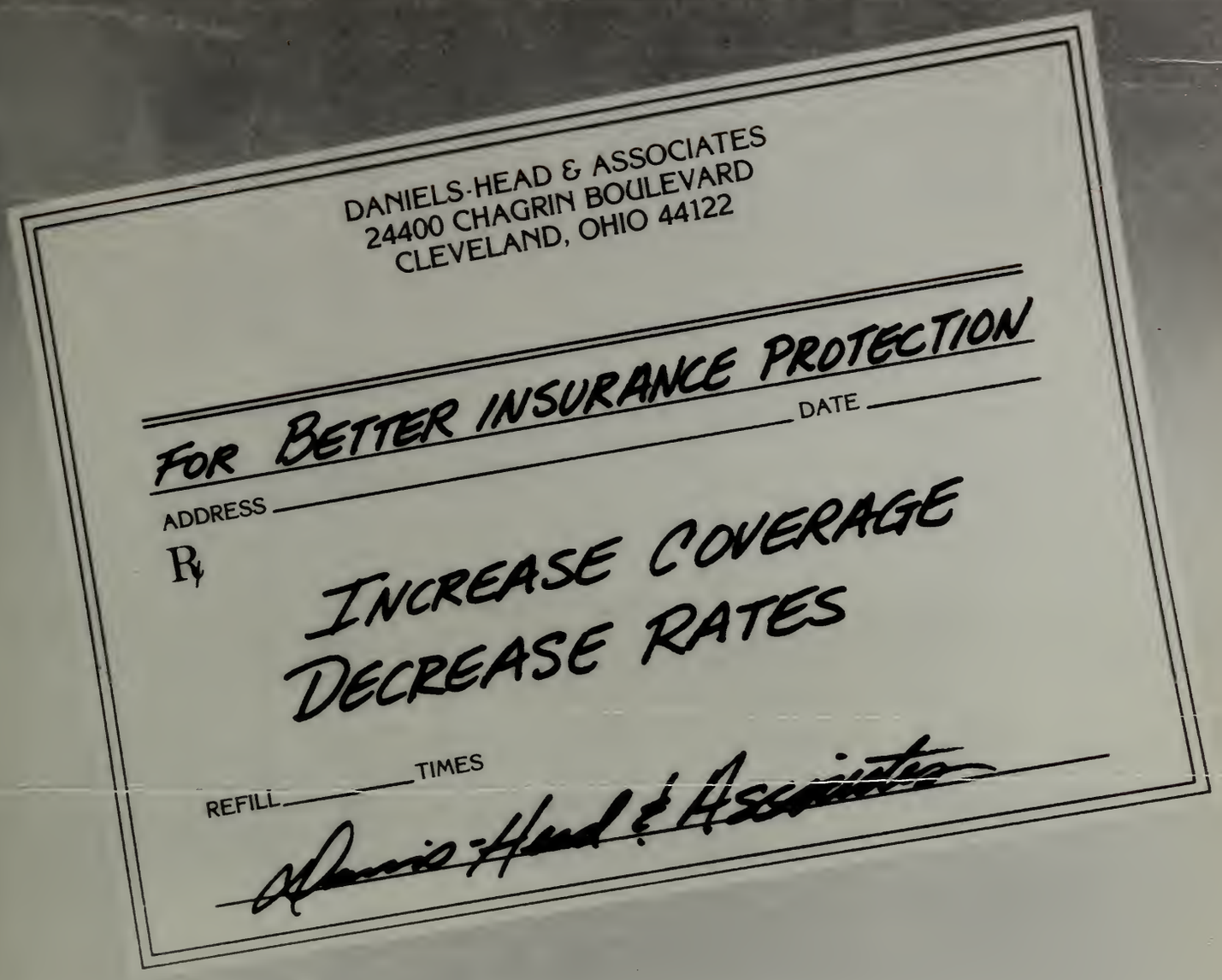
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For most physicians, reducing income taxes to the minimum is a goal. Income tax reduction, however, takes many forms, from charitable gift-giving to investments in the most highly leveraged and speculative tax shelter "deals." Most tax sheltered investments are made in a crisis atmosphere to obtain a multiple write-off of one's investment to produce in a high tax bracket a "return" from nothing more than saved taxes. The mature investor, however, knows that tax shelters are no more than tax deferral arrangements and that ultimately the investor will experience the dark side of the moon of phantom income, unrealized appreciation assumptions, loss of liquidity, and the loss of principal. But is tax shelter investing to be avoided because of the risk? The answer is no. All investing is the balance of risk and reward and thus it is only natural that investors should be motivated to achieve the highest return with the lowest risk.

The lowest risk investment would be one in which the return could be securely predicted and supported by law. The investment would enable a business or individual to deduct the cost, and the investment would grow at a yield which would be not only predictable and manageable but without current income tax consequence to the investor. At the completion of such an arrangement, the "sale" or withdrawal of funds from the investment would be treated with special income tax preferences such as are available to capital gains transactions and installment sales. Such an arrangement would logically be implemented by investors before speculating on investments with high risk, but which did not promise a comparative return.

This investment and tax planning opportunity is available in the form of a defined benefit pension plan. Sanctioned by law, it offers a vehicle for superior net worth growth without investment risk. Accumulating adequate assets for retirement is typically viewed by the average middle-aged physician as the most important economic goal and the sole purpose for long term investing. It is with this financial planning goal in mind and the unparalleled income tax benefits that inure to the physician who implements a defined benefit pension plan that such plans have been widely used by physicians seeking the satisfaction of retirement and income tax planning goals.

The concept of equity transfer is often used to justify large contributions to such an arrangement. Equity transfer is the concept of redeploying after tax assets to tax deferred assets by reducing a business salary through a corporation, partnership, or sole proprietorship in order to make such funds available for contributions to the defined benefit pension plan. At the same time the physician consumes personal after tax accumulated funds for living expenses, thereby avoiding all the tax on what would have been earned income. If a physician can avoid taking $100,000 of income from his practice and if he or she is in an average income tax bracket of 40%, he will avoid paying $40,000 of tax and if that $100,000 is available for contribution to a defined benefit pension plan, not



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The Best Tax Shelter . . . *continued*

only does the physician save the income tax that he would have otherwise paid on the $100,000 income, but the $100,000 of contribution to the defined benefit plan is now sheltered within the statutory protective arms of the pension plan to be invested until withdrawn and not taxed until then. Classically, defined benefit pension plan and the concept of equity transfer is considered by middle-aged and older physicians who have more income than they require for their living expenses; their children having completed college, and their mortgage having been paid. Or they have adequate personal resources from their after-tax savings, inheritances or otherwise to allow a reduction in the "salary" from their practice.

Recently, a 60-year-old internist with a young staff terminated his traditional money purchase pension and profit sharing plan in which he was limited to a $30,000 contribution and implemented a defined benefit pension plan which permitted a $100,000 contribution for his account by contrast to the $30,000 of contribution under the former plan. The contribution on behalf of his staff did not decline but he was able through the technique of equity transfer and the use of a defined benefit plan to increase his tax deductible retirement plan contributions from $35,000 to $105,000 and avoided the income tax on $70,000 of income with the resultant tax savings of over $25,000! In five years, the physician has been able to accumulate almost $700,000.

Every physician who can afford to contribute more than $30,000 to a retirement fund should investigate the advantages of a defined benefit pension plan. But understanding a defined benefit pension plan is not an easy task. When one thinks of profit sharing, it is based on a simple contribution of a percentage of one's income which is allocated to a fund and which grows with investment results. Defined benefit pension plans on the other hand do not define the contribution but rather the benefit, and the benefit is described as a percentage or unit value of compensation. When an employer adopts a defined benefit plan, the employer promises to establish a fund which is adequate to pay for the promised benefits. Under current law the benefit cannot exceed $90,000 per year or 100% of one's highest averaged compensation whichever is less. But if the time required to fund such a benefit is limited because of the age of the participant, and retirement is fast approaching, as would be the case with the 50- to 60-year-old physician, the required contributions will be substantially higher than if the same benefit were promised to a younger plan participant. It is a simple matter of amount of time to achieve a stated goal. It is the business' obligation to provide adequate funds to the pension trust to satisfy the goal, whatever the contribution may be or whatever the investment return.

Investing for defined benefit plans takes a different twist to the typical capital gains type investing for defined contribution plans. Here the physician/plan trustee is trying to maximize contributions and should consider the defined benefit plan as the conservative part of his personal portfolio. Thus, investments in income producing rather than capital gain oriented investments is preferred. Also, additional contributions for life insurance may be effective in the defined benefit plan where typically not recommended for the defined contribution plan. During the funding period, until the physician reaches his normal retirement age, funding will vary, depending on investment results, employee turnover and the actuarial funding method chosen. Only in the most unusual circumstances would the establishment of a defined benefit pension plan require a commitment to a fixed contribution. Indeed, the actuarial science is so flexible and the assumptions so variable that a contribution range can be almost as flexible as one desires. In addition, the plan sponsor always reserves the right, subject to the facts and circumstances of his intentions, to either change the benefit or terminate the plan. It is true that the administration of a defined benefit plan is slightly more complex because of the unfamiliar nature of a defined benefit concept by contrast to an allocated profit sharing fund. Also, the actuarial expense is an added cost, but, in investment and tax savings terms, well worth it.

A decision model for considering a defined benefit plan would be based on the following criteria:

1. Are you over age 45?
2. Can you afford to contribute more than $30,000 to your retirement plan?

3. Is your staff young in relation to yourself?
4. Is your compensation relatively high in relation to your staff compensation?
5. Do you have a retirement plan objective that requires additional funding beyond that which will be accumulated by the $30,000/25% variety retirement plan?
6. Do you desire additional risk-free income tax shelter?

If the answer to any of these questions or a combination is yes, you should make a note to yourself to inquire of your retirement plan attorney, accountant, retirement plan administrator or financial planner to discuss the merits of a defined benefit plan. Individual and comparable plans can be established for physicians in a multishareholder or partnership practice. That is, a defined benefit plan can be installed for an older physician who answers yes to some of the criteria questions, while the younger members maintain their money purchase and profit sharing plans.

CAVEAT: Don't buy risky tax shelters when there is one that is guaranteed!

James L. Budros holds the professional designations of Certified Financial Planner (CFP), Chartered Financial Consultant (ChFC), and Chartered Life Underwriter (CLU). He is a member of the Institute of Certified Financial Planners, the International Association for Financial Planning, and is among the select

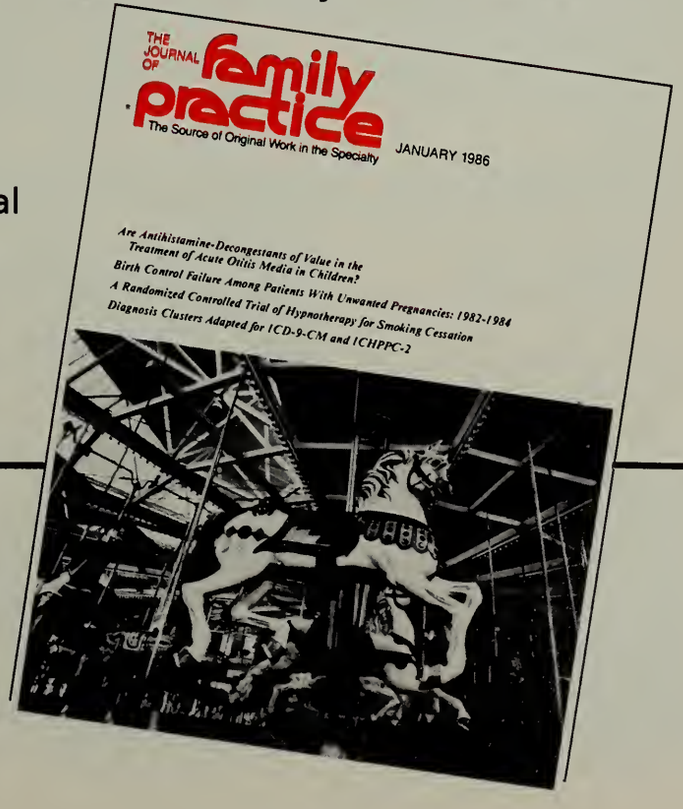
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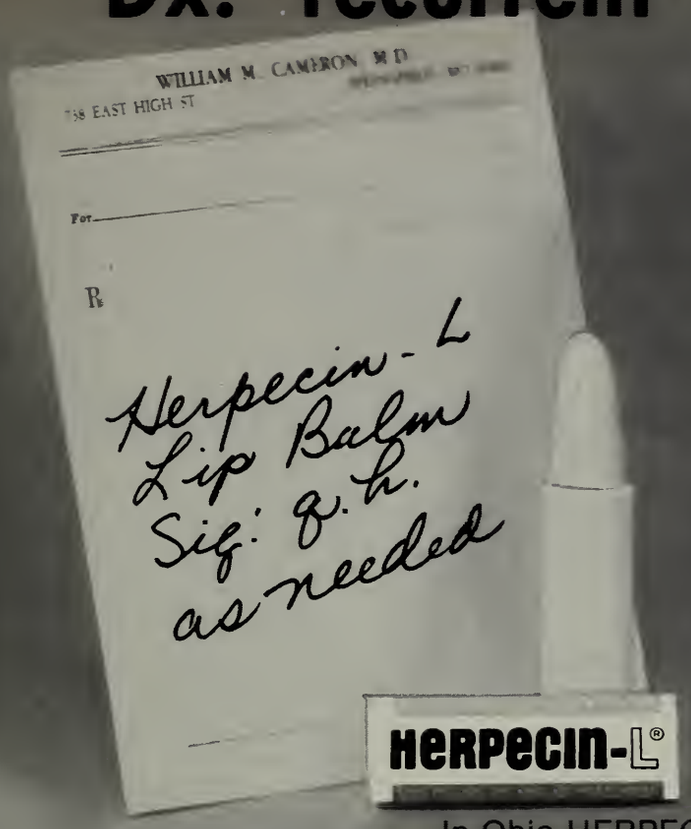
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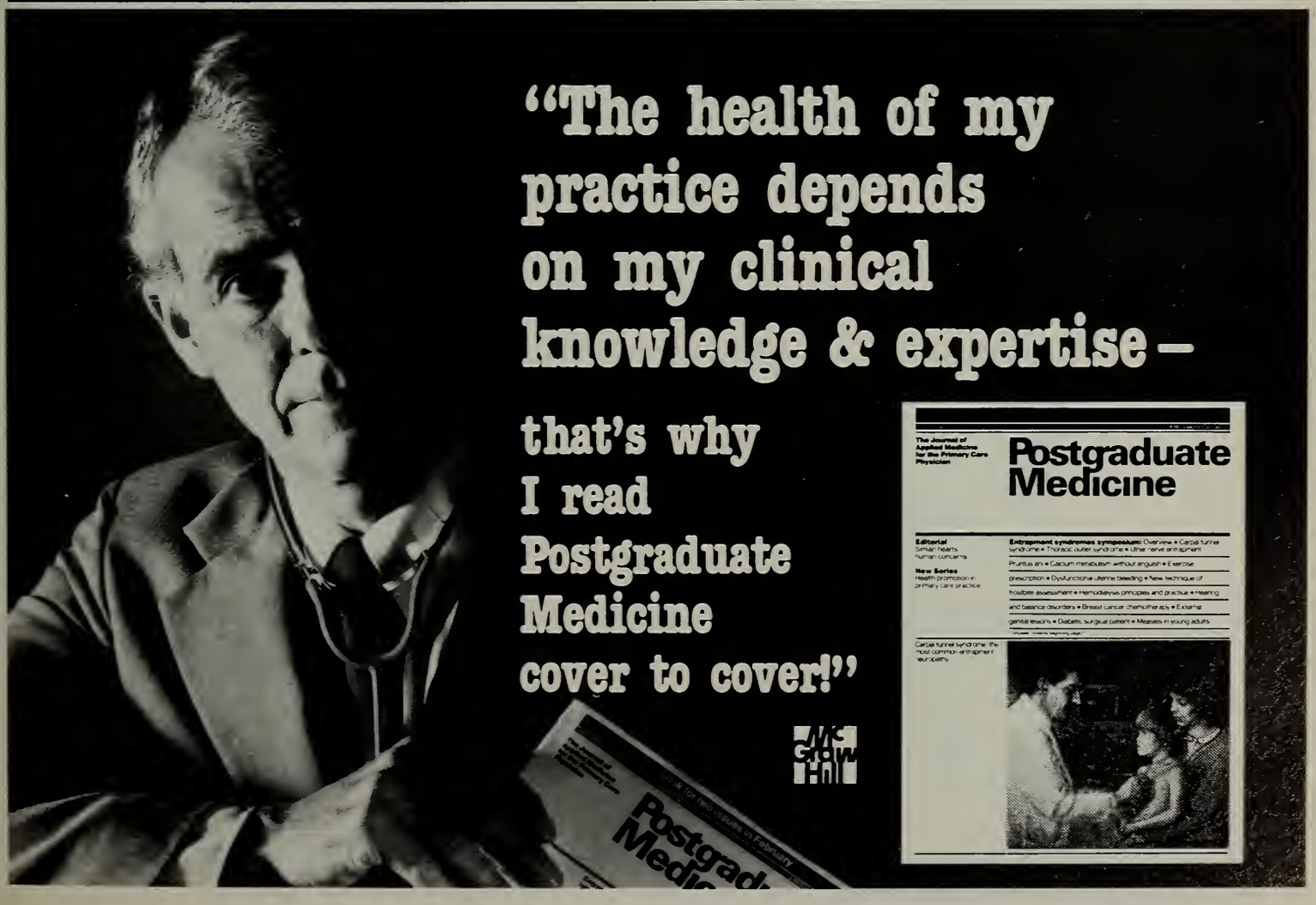
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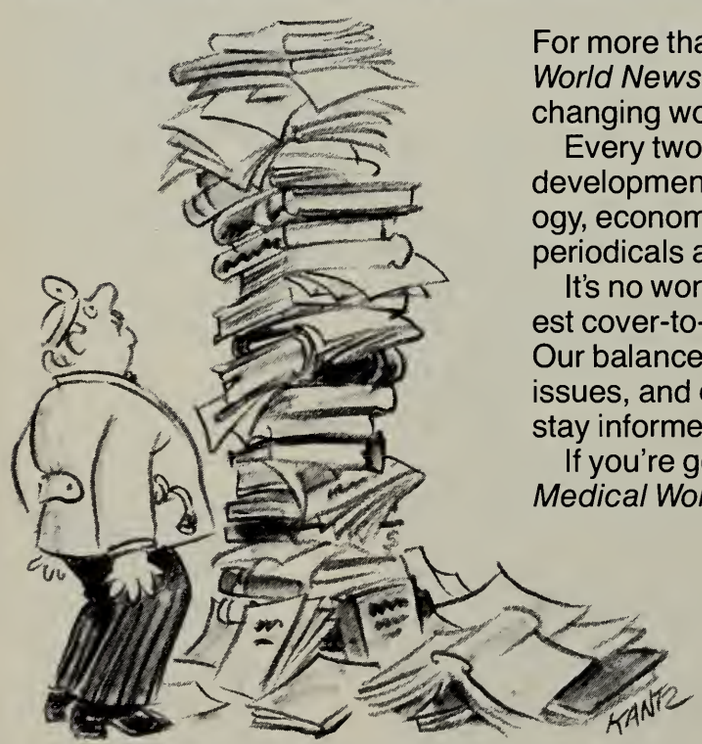
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Obituaries

SAMUEL BECKERMAN, MD, Cleveland; Case Western Reserve University School of Medicine, 1935; age 73; died February 15, 1986; member OSMA and AMA.

EUGENE A. CAPOCASALE, MD, Zanesville; Facolta di Medicina d Chirurgia dell' University di Torino, Torino, Italy, 1956; age 61; died February 17, 1986; member OSMA and AMA.

CHRISTINE CARTER, MD, Cincinnati; University of Louisville School of Medicine, Louisville, Kentucky, 1933; age 75; died October 22, 1985; member OSMA and AMA.

ELMER G. CASKEY, MD, Mineral Ridge; Rush Medical College, Chicago, Illinois, 1932; age 80; died February 21, 1986; member OSMA and AMA.

ANTHONY D. FROGAMENI, MD, Toledo; Facolta di Medicina e Chirurgia dell' di Bologna, Bologna, Italy, 1962; age 52; died February 16, 1986; member OSMA and AMA.

DOUGLAS GOLDMAN, MD, Cincinnati; University of Cincinnati College of Medicine, 1929; age 80; died February 7, 1986; member OSMA and AMA.

ROBERT B. HINES, MD, Uhrichsville; Ohio State University College of Medicine, 1940; age 73; died February 28, 1986; member OSMA and AMA.

RICHARD J. HONARD, MD, Cleveland; St. Louis University School of Medicine, 1954; age 60; died February 19, 1986; member OSMA and AMA.

LEWIS C. INSKEEP, MD, Urbana; University of Cincinnati College of Medicine, 1932; age 79; died February 9, 1986; member OSMA and AMA.

ROLAND S. JAUCH, MD, Rocky River; Ohio State University College of Medicine, 1925; age 86; died February 16, 1986; member OSMA and AMA.

CORNELIUS C. LANDEN, MD, Columbus; Ohio State University College of Medicine, 1930; age 78; died February 27, 1986; member OSMA and AMA.

IRENE C. LAZDINS, MD, Delaware; Latvijas Universitate Medicinas Fakultate, Riga, Latvia, 1940; age 71; died November 28, 1985; member OSMA and AMA.

DONALD J. LYLE, MD, Cincinnati; University of Cincinnati College of Medicine, 1919; age 89; died February 20, 1986; member OSMA and AMA.

continued on page 340



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"I Trained with the Reds"

by V.N. Carrico, MD

On February 2, 1986, I realized a dream come true. I went to Tampa, Florida, along with 71 others, to the Reds spring training camp as a "rookie." As a "dream weeker" — one of those selected to spend a week with the Cincinnati Reds — I had earned the right to be there. But it hardly seemed possible.

As a kid growing up in Dayton, Ohio, I lived and breathed the Cincinnati Reds — Roy McMillin, Ed Bailey, Ted "Big Klu" Kluzewski, Joe Nuxall. I listened to every game, knew all the statistics, and traveled to Crosley Field whenever possible. My goal, of course, was to be a major league player.

Even during my premed days, as a student at Wabash College, I followed the Reds with enthusiasm — and even managed to play college baseball. But, alas, no "scouts," no "bonus baby," no contracts came my way. I had to settle on medical school at Indiana University.

Then, in the summer of 1985, I heard of "Dream Week" — the first for the Cincinnati Reds. I, along with three other Bryan, Ohio residents — Ric Gilmer and Stan Tipton, both dentists, and Greg Spangler, president of Spangler Candy Company — signed our "bonus payment" — $2,795 to be a "Red for a week."

Before our week began, we were able to choose our uniform number. My choice was number two — the number my deceased daughter, Sandra, wore during her seven years as a player on the girls softball team I coached. The uniform number added extra meaning to my week in Florida.

Now to set the record straight. I hadn't played baseball for 24 years. I had played some softball, and had coached the girls softball team, and had made frequent trips to Riverfront Stadium — but that fell short of any *specific* baseball experience.

So, to prepare ourselves for our experience, the four of us from Bryan began to train in Spangler's warehouse, and had some batting practice at an indoor batting cage in Toledo before we headed for Tampa.

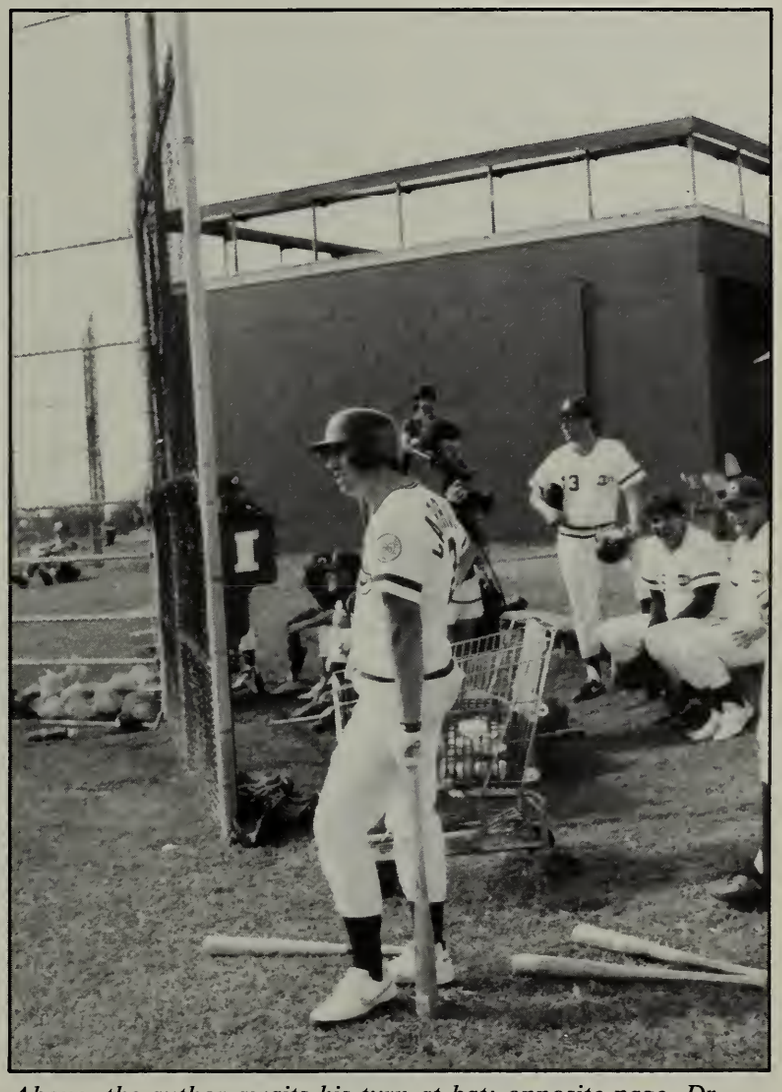
The first night there, we attended a beer and chicken wing party at "Hooters" — a hangout

for ball players. There, I encountered some of my heroes — Big Klu, Ed Bailey, Jim O'Toole, Joe Nuxall and others. There was an exchange of old baseball stories, and an insightful, behind-the-scenes look at the sport that continued throughout the week.

Monday was the first day of practice. We did calisthenics, baseball drills, and had two intersquad games. My best hitting experience that week happened my first time at bat — with runners on second and third. I managed to hit one over the center fielder's head for a double and two RBIs. I felt great — and went four for five that day.

The remainder of the week consisted of batting practice, baseball drills and intersquad games with our own teams — there were six of them — and games with "Dream Week" teams from the Baltimore Orioles and the New York Mets.

My coach during my tenure was Tommy Helm, the Reds present first base coach and ex-rookie of the year; and during the week, I made many trips to the training room to see Larry Starr, the Reds trainer. They do an excellent job on sports-related injuries — an eduction in itself — though not the "deductible" kind. There were four MDs, including myself, attending that week. David Joffe, MD, from Dayton, and Ralph Lach, MD, from Columbus, were there. Both are cardiologists, but, fortunately, their skill was not needed that week.



Above, the author awaits his turn at bat; opposite page, Dr. Carrico in the outfield.

Our final game was played at Al Lopez Field in Tampa on Saturday, against some of the old Reds. Unfortunately, the game was rained out before it could be completed — but that didn't make a bit of difference to me. The week had been my dream fulfilled.

Dream week is not over yet. In July, we will be honored at a Reds game in Cincinnati in full uniform.

So, if you have ever played baseball — are willing to endure a few sore muscles — and would like to hobnob with all those great ex-ballplayers — the Cincinnati Reds' dream week may be just what you're looking for.

See you at Riverfront Stadium in July!

V.N. Carrico, MD, has a family practice in Bryan, Ohio.

Obituaries . . . *continued*

HAROLD K. MOSS, MD, Cincinnati; University of Cincinnati College of Medicine, 1937; age 84; died February 2, 1986; member OSMA and AMA.

JAMES R. PARKER, MD, Delaware; St. Louis University School of Medicine, 1959; age 52; died February 20, 1986; member OSMA and AMA.

JAMES M. SHAFFER, MD, Dayton; Northwestern University Medical School, Chicago, Illinois, 1937; age 75; died February 21, 1986; member OSMA and AMA.

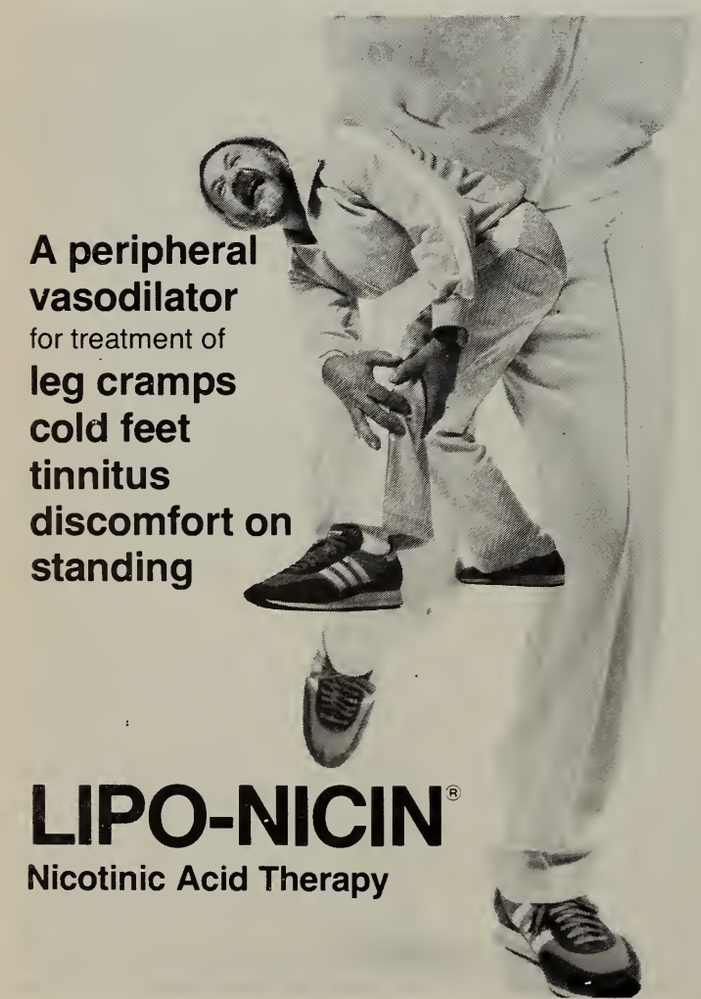
WILLIAM E. SHAW, MD, Cincinnati; University of Cincinnati College of Medicine, 1944; age 66; died February 27, 1986; member OSMA and AMA.

CLYDE M. SPEICHER, MD, Lighthouse Point, Florida; Ohio State University College of Medicine, 1929; age 83; died February 20, 1986; member OSMA and AMA.

ERICH SPIRO, MD, Portsmouth; Medizinische Fakultaet der Johann Wolfgang Goethe University Frankfurtam-Main, Hessen, Germany, 1937; age 76; died February 14, 1986; member OSMA and AMA.

A. W. VERHOFF, MD, Columbus; Ohio State University College of Medicine, 1931; age 81; died March 7, 1986; member OSMA and AMA.

THEODORE H. WINANS, MD, Fairborn; Hahnemann Medical College of Philadelphia, Pennsylvania, 1927; age 86; died February 2, 1986; member OSMA and AMA.



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DIAGNOSIS & TREATMENT OF HEADACHES IN ADULTS AND CHILDREN: May 7; Bunts Auditorium, Cleveland Clinic; sponsor: The Cleveland Clinic Educational Foundation; 6 credit hours; fee: $90 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

ORTHOPEDICS FOR PRIMARY CARE: May 7; The Marriott Hotel, Dayton; sponsor: Wright State University School of Medicine; 7 credit hours; fee: $65 faculty, $75 other physicians, $40 others; contact: Cheryl Little, Wright State University, Postgraduate Medicine and Continuing Education, Xenia 45385, phone: 513/429-3200 Ext. 5411.

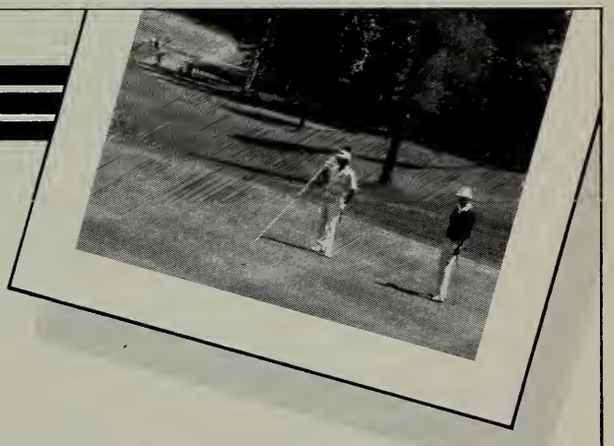
LEARNING DISABILITIES: May 14-15; Bunts Auditorium, Cleveland Clinic; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: $170 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

MACDONALD HOSPITAL FOR WOMEN ANNUAL, REVIEW OF OB/GYN: May 15-17; Cleveland Hilton South, Cleveland; sponsor: Case Western Reserve University School of Medicine; jointsponsor: MacDonald Hospital for Women; 16 credit hours; fee: $200, $150 other health professionals; contact: Jean Ken Korman, 2119 Abington Rd., Cleveland 44106, phone: 216/368-2408.

ORTHOPAEDIC REVIEW COURSE: May 18-26; Quail Hollow Inn, Painesville; sponsor: Case Western Reserve University School of Medicine; jointsponsor: University Hospitals of Cleveland; 47 credit hours; fee: $800; contact: Jean Ken Korman, 2119 Abington Rd., Cleveland 44106, phone: 216/368-2408.

31st Annual Meeting of the Ohio Chapter of the American College of Surgeons; May 22-24, 1986; Hotel Sofitel Toledo, Toledo, Ohio; co-sponsored by the Ohio Chapter, ACS, and the American College of Surgeons; 15 credit hours Category I; fee: $100/members, $150/non-members, $25/residents; contact: Gerald Stark, M.D., 5800 Monroe Street, P.O. Box 8100, Sylvania 43560, phone: 419/885-3551.

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EMERGENCY PHYSICIAN NEEDED to complete staffing for community emergency department and urgent care center. Opportunity for qualified physician to join current five member emergency medicine residency trained group to staff community hospital with 30,000 annual visits and associated urgent care center with 24,000 annual visits. First year compensation over $100,000, good pathology and excellent backup available. Group goal is for equal shareholder status of all full-time employees. Contact Roger L'Hommedieu, MD, Chairman, Department of Emergency Medicine, Robinson Memorial Hospital, 6847 North Chestnut Street, Ravenna, Ohio 44266; area code 216-297-0811, extension 2194.

FAMILY PRACTITIONERS
Board eligible/certified family practitioners to associate with board certified general surgeon. Guarantee: competitive salary, benefits, coverage, full privileges. 24 hour emergency room coverage. Contact: Village Medical Clinic, 1814 Enslee Road, Coshocton, OH 43812. Phone: 614-622-7497 after 7:00 p.m.

FOSTORIA, OHIO — Directorship and full time emergency department position available at moderate volume facility within one hour drive of Toledo. Attractive compensation with malpractice insurance provided. Please submit resume to Emergency Consultants, Inc., 2240 South Airport Road, Room 26, Traverse City, MI 49684; or call 1-800-253-1795 or in Michigan 1-800-632-3496.

HOLISTIC DOCTOR. Compensation $25-$30 per hour plus percentage. Solo practice. All equipment, personnel furnished. No start-up fees. Excellent growth potential. Send CV and recent photo to: MLG Health Care Corporation, 1100 Wilmington Ave., Dayton, OH 45420.

INDIANA — Position immediately available. New walk-in medical facility . . . guaranteed salary . . . fee for service incentives . . . regular hours. Please reply to P.O. Box 461, Terre Haute, Indiana 47807.

INTERNAL MEDICINE. ABIM internist seeks same to join his busy solo practice in southeastern Ohio. Must have recent experience in critical care procedures and enjoy primary care internal medicine. Nice family town. Send CV to Ohio State Medical Journal, c/o Box No. 84, 600 South High Street, Columbus, Ohio 43215.

MARIETTA, OHIO — Emergency Department directorship and staff position available at 200 bed facility. Board certification or board eligibility in Emergency Medicine or primary specialty preferred. Contact: Emergency Consultants, Inc., 2240 S. Airport Road, Room 26, Traverse City, MI 49684; or call 1-800-253-1795, in Michigan 1-800-632-3496.

OHIO BC/BE PEDIATRICIAN WANTED to join a four-person primary care clinic of Family Practice and OB/GYN. Salaried position with good fringe benefits. Respond with resume to P.O. Box 747, Greenville, Ohio 45331.

OHIO: Career-oriented emergency physician needed for full-time emergency position in a modern community hospital in Northwest Ohio. Moderate volume, competitive salary, malpractice insurance and flexible schedule. Position available immediately. Send resume to P.O. Box 85, c/o Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

OHIO — LAKE ERIE SHORES — SANDUSKY
Full time family practice physician with E.R. experience for director of family practice urgent care center. Facility is well equipped and centrally located. Mostly Mon. thru Fri. with occ. weekend. Position offers $65,000 base with percent of production. Malpractice and medical included. Contact: Chuck Kimes, 419-626-4235.

URGENT CARE CENTER AND ER PHYSICIANS — CLEVELAND, OHIO
Our caseload is up. Medical Emergency Services operates freestanding urgent care centers and staffs hospital emergency rooms. We operate three successful Immediate Medical Care urgent care centers in the greater Cleveland suburban area. We will be opening two additional centers within the next 12 months.

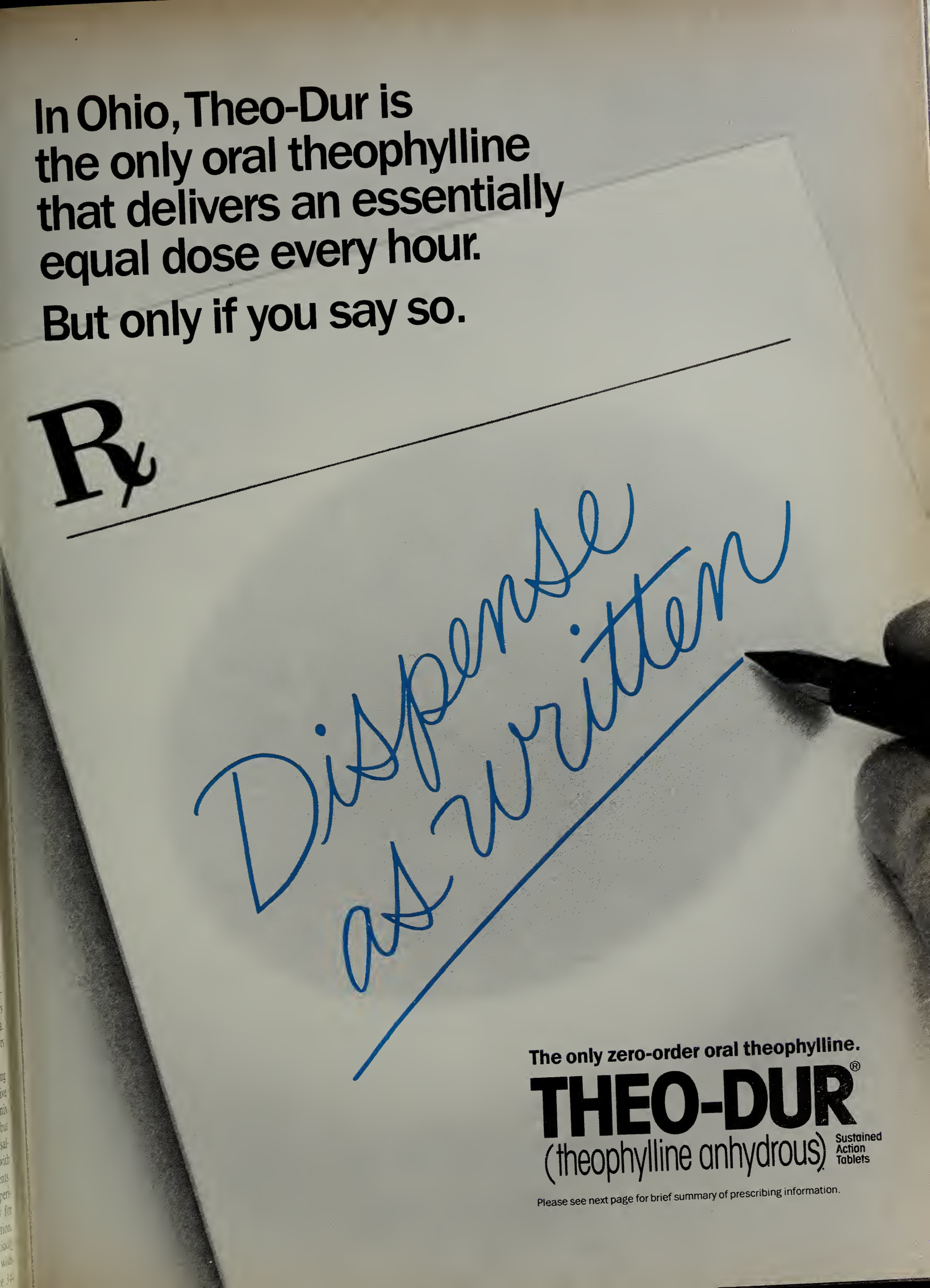
We offer the opportunity of practicing medicine in a pleasant and supportive atmosphere with an attractive case mix and top notch staff. You work hard, but have regular hours and an excellent salary. We take care of supporting you with staff, equipment, facilities and patients.

After we both have had some experience together, there is opportunity for stock participation in our organization. If you want to concentrate on practicing medicine, and earn a good income with-

continued on page 344

In Ohio, Theo-Dur is the only oral theophylline that delivers an essentially equal dose every hour.

But only if you say so.



The only zero-order oral theophylline.

THEO-DUR®
(theophylline anhydrous) Sustained Action Tablets

Please see next page for brief summary of prescribing information.

THEO-DUR®

(theophylline anhydrous) Sustained Action Tablets

Today's most widely prescribed bronchodilator.

Description: THEO-DUR sustained action tablets contain anhydrous theophylline, a bronchodilator, in a sustained release formulation (with no color additives) which allows a 12-hour dosing interval for a majority of patients and a 24-hour dosing interval for selected patients.

Clinical Pharmacology: Theophylline directly relaxes the smooth muscle of the bronchial airways and pulmonary blood vessels, thus acting mainly as a bronchodilator and smooth muscle relaxant. The drug also produces other actions typical of the xanthine derivatives: coronary vasodilator, cardiac stimulant, diuretic, cerebral stimulant, and skeletal muscle stimulant. The actions of theophylline may be mediated through inhibition of phosphodiesterase and a resultant increase in intracellular cyclic AMP. Apparently, no development of tolerance occurs with chronic use of theophylline.

Indications: THEO-DUR is indicated for relief and/or prevention of symptoms of bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Contraindications: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the tablet components.

Warnings: Excessive theophylline doses may be associated with toxicity; serum theophylline levels should be monitored to insure maximum benefit with minimum risk. Incidence of toxicity increases at serum levels greater than 20 mcg/ml. High blood levels of theophylline resulting from conventional doses are correlated with clinical manifestation of toxicity in: patients with lowered body plasma clearances, patients with liver dysfunction or chronic obstructive lung disease, and patients who are older than 55 years of age, particularly males. There are often no early signs of less serious theophylline toxicity such as nausea and restlessness, which may occur in up to 50% of patients prior to onset of convulsions. Ventricular arrhythmias or seizures may be the first signs of toxicity. Many patients who have higher theophylline levels exhibit tachycardia. Theophylline products may worsen pre-existing arrhythmias.

Precautions: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hourly or sometimes 8 hourly intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.

Usage in Pregnancy: Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthines to a mother who is nursing, taking into account the risk-benefit of this therapy.

Pediatric Use: Safety and effectiveness of THEO-DUR administered every 24 hours in children under 12 years of age, and every 12 hours in children under 6 years of age, have not been established.

Adverse Reactions: The most consistent adverse reactions are usually due to overdose and are:

Gastrointestinal: nausea, vomiting, epigastric pain, hematemesis, diarrhea.

Central nervous system: headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.

Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias.

Respiratory: tachypnea.

Renal: albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis.

Others: rash, hyperglycemia and inappropriate ADH syndrome.

How Supplied: THEO-DUR 100 mg, 200 mg and 300 mg sustained action tablets are available in bottles of 100, 500, 1000 and 5000, and in unit dose packages of 100.

Caution: Federal law prohibits dispensing without prescription. For full prescribing information, see package insert.

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out the hassle and expense of running an office, then this can be the opportunity for you.

Please send CV to Medical Emergency Services, Inc., 6133 Rockside Rd., Suite 10, Cleveland, OH 44131, or call 216-642-1400.

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MEDICAL PRACTICE SALES AND APPRAISALS: We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our brokerage division at: The Health Care Group, 500 GSB Building, Bala Cynwyd, PA 19004 (215) 667-8630.

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SURGERY GENERAL — New Jersey — Attractive practice near New York City.

We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice, contact our Brokerage Division at: Health Care Personnel Consulting, 403 GSB Building, Bala Cynwyd, Pa. 19004.

PEDIATRIC PRACTICE FOR SALE: Retiring pediatrician is selling well-established, busy practice that is located in a suburb southwest of Cleveland. Annual gross is approximately $150,000. Selling price is $70,000. Seller will help finance. Reply to Ralph P. Higgins, Attorney, 21010 Center Ridge Road, Rocky River, Ohio 44116.

Medical Equipment

EQUIPMENT WANTED

Used Xerox Copy Machine, Model #3107 or 3109, LDC. Reply to Box #87, c/o Ohio State Medical Journal, 600 S. High St., Columbus, Ohio 43215.

Real Estate

FOR SALE: Recently retired MD office building (apartments pay overhead on building). Excellent hospital facility in fine city of 18,000. Contact me at 216/332-4959, 836 S. Lincoln Ave., Salem, OH 44460.

OFFICE SPACE AVAILABLE

Share office space in prime Boardman, Ohio location, 412-654-6660.

Services

FREE LANCE EDITOR. Experienced medical editor would like to assist physicians in preparation of scientific articles and textbooks. Can also produce patient information brochures that are uniquely suited to your practice. My knowledge of printing, typesetting and graphic design can turn your rough draft into a professionally produced communication tool. For more information contact: Esther Weiss, 76 South High Street, Gahanna, Ohio 43230. Telephone (evenings): (614) 476-5489.

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Quality Scanning for reel or cassette type recorders by qualified technicians and certified cardiologists' interpretations scan price $35.00 with UPS speedy delivery. Recorders loaned, leased or purchase new dual channel holter recorders, $995.00, with one year warranty. For more information call advance medical and research center 1-800-552-6753.

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NORTHERN OHIO — FAMILY PHYSICIAN to associate with established practice. Obstetrics optional with excellent back-up, well-equipped 200 bed hospital offers full privileges, beautiful community of 25,000, diversified economy, easy access to medical school and several universities. Reply in confidence: Anne Sondek, Director of Primary Care, Four-O Vermont Street, Buffalo, New York 14213, (716) 884-3700.

Strong on results. Simple to take.



In recurrent urinary tract infections

Highly effective against a wide range of susceptible uropathogens:

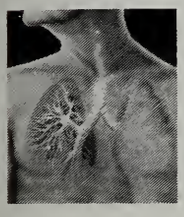
Escherichia coli
Klebsiella spp.
Enterobacter spp.
Proteus mirabilis
Proteus vulgaris
Morganella morganii



In acute otitis media in children

Clears middle-ear fluid of the most common susceptible pathogens:

Streptococcus pneumoniae
Haemophilus influenzae
(even ampicillin-resistant strains)



In acute exacerbations of chronic bronchitis in adults

Clears the sputum of important susceptible pathogens:

Streptococcus pneumoniae
Haemophilus influenzae

Not indicated for prophylactic or prolonged administration in otitis media at any age; contraindicated in infants less than two months of age.

Bactrim™ (trimethoprim and sulfamethoxazole/Roche)

Effective and versatile *b.i.d.* therapy

Before prescribing, please consult complete product information, a summary of which follows:

CONTRAINDICATIONS: Hypersensitivity to trimethoprim or sulfonamides; documented megaloblastic anemia due to folate deficiency; pregnancy at term and during the nursing period; infants less than two months of age.

WARNINGS: FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently.

BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS:

General: Give with caution to patients with impaired renal or hepatic function, possible folate deficiency and severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur, frequently dose-related.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently; if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffé alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenesis: Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. *Mutagenesis:* Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. *Impairment of Fertility:* No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folic acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS and CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).** *Hematologic:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, methemoglobinemia, eosinophilia. *Allergic Reactions:* Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. Periarteritis nodosa and systemic lupus erythematosus have been reported. *Gastrointestinal:* Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. *Genitourinary:* Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. *Neurologic:* Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. *Psychiatric:* Hallucinations, depression, apathy, nervousness. *Endocrine:* Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. *Musculoskeletal:* Arthralgia, myalgia. *Miscellaneous:* Weakness, fatigue, insomnia.

DOSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN: *Usual adult dosage* for urinary tract infections is one DS tablet, two tablets or four teaspoonfuls (20 ml) *b.i.d.* for 10 to 14 days. Use identical daily dosage for 5 days for shigellosis. *Recommended dosage for children* with urinary tract infections or acute otitis media is 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses every 12 hours for 10 days. Use identical daily dosage for 5 days for shigellosis. *Renal Impaired:* Creatinine clearance above 30 ml/min, give usual dosage; 15-30 ml/min, give one-half the usual regimen; below 15 ml/min, use not recommended.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS: Usual adult dosage is one DS tablet, two tablets or four teasp. (20 ml) *b.i.d.* for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS: Recommended dosage is 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

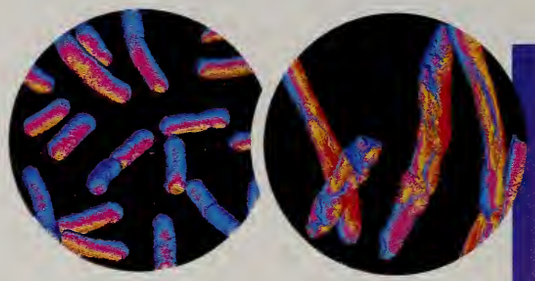
HOW SUPPLIED: *DS (double strength) Tablets* (160 mg trimethoprim and 800 mg sulfamethoxazole—bottles of 100, 250 and 500; Tel-E-Dose* packages of 100; Prescription Paks of 20. *Tablets* (80 mg trimethoprim and 400 mg sulfamethoxazole)—bottles of 100 and 500; Tel-E-Dose* packages of 100; Prescription Paks of 40. *Pediatric Suspension* (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 100 ml and 16 oz (1 pint). *Suspension* (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 16 oz (1 pint).

STORE TABLETS AT 15°-30°C (59°-86°F) IN A DRY PLACE PROTECTED FROM LIGHT.

STORE SUSPENSIONS AT 15°-30°C (59°-86°F) PROTECTED FROM LIGHT.

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Strong on results. Simple to take.



before *E. coli* culture—color-enhanced scanning electron microscopy (SEM).

after *E. coli* destroyed by Bactrim 5 × MIC *in vitro*. (*In vitro* data do not necessarily correlate with clinical results.)





before *H. influenzae* culture—color-enhanced SEM.

after *H. influenzae* destroyed by Bactrim 5 × MIC *in vitro*. (*In vitro* data do not necessarily predict clinical results.)



before Otoscopic view of tympanic membrane in a patient who did not respond to ampicillin therapy.

after Same patient after ten days of Bactrim therapy.

In recurrent UTI,
acute exacerbations of chronic bronchitis
and acute otitis media

Bactrim™ (trimethoprim and sulfamethoxazole/Roche) ROCHE®

Effective and versatile *b.i.d.* therapy

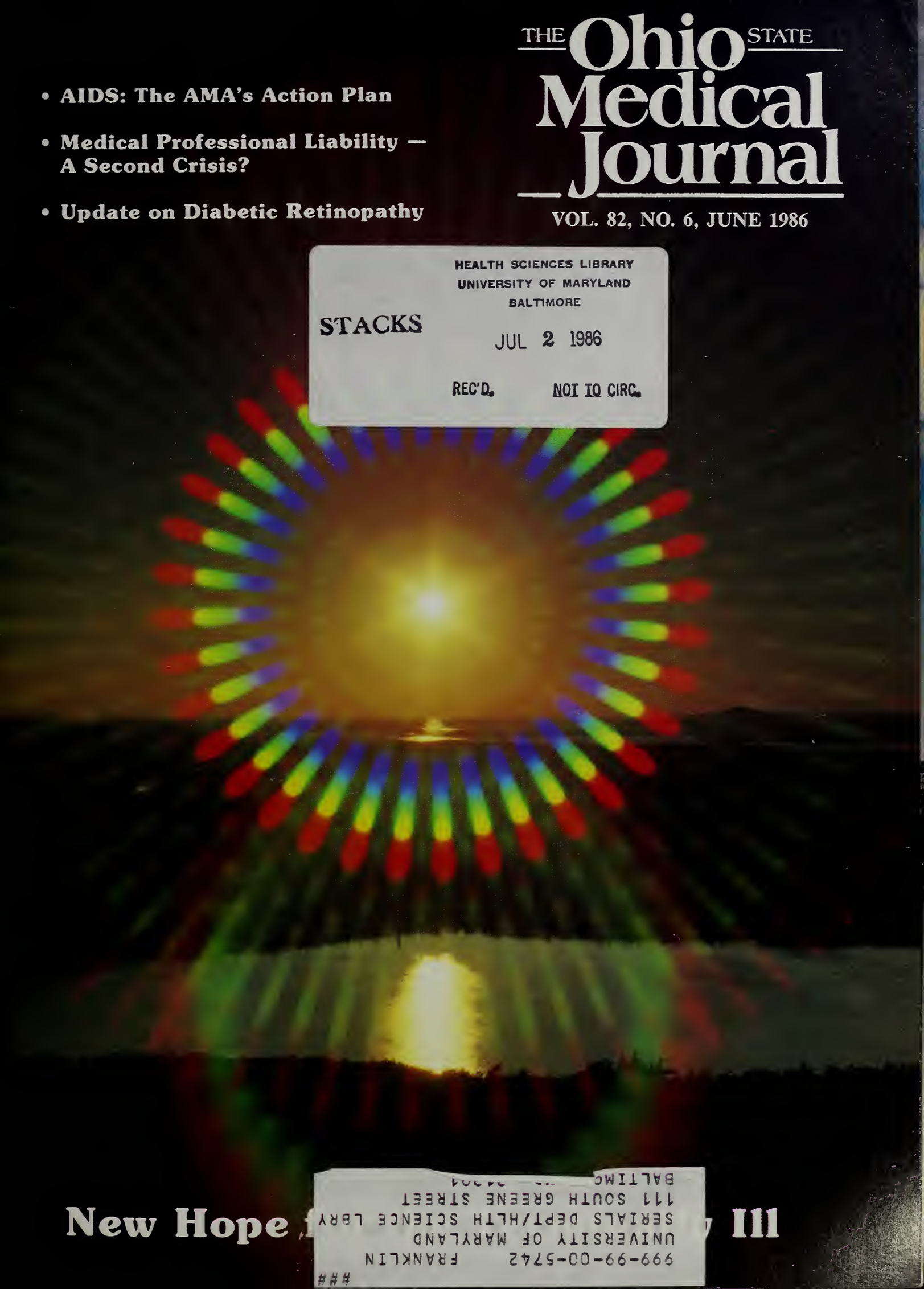
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Please see preceding page for a summary of product information.

THE Ohio STATE
Medical Journal
VOL. 82, NO. 6, JUNE 1986

- **AIDS: The AMA's Action Plan**
- **Medical Professional Liability — A Second Crisis?**
- **Update on Diabetic Retinopathy**

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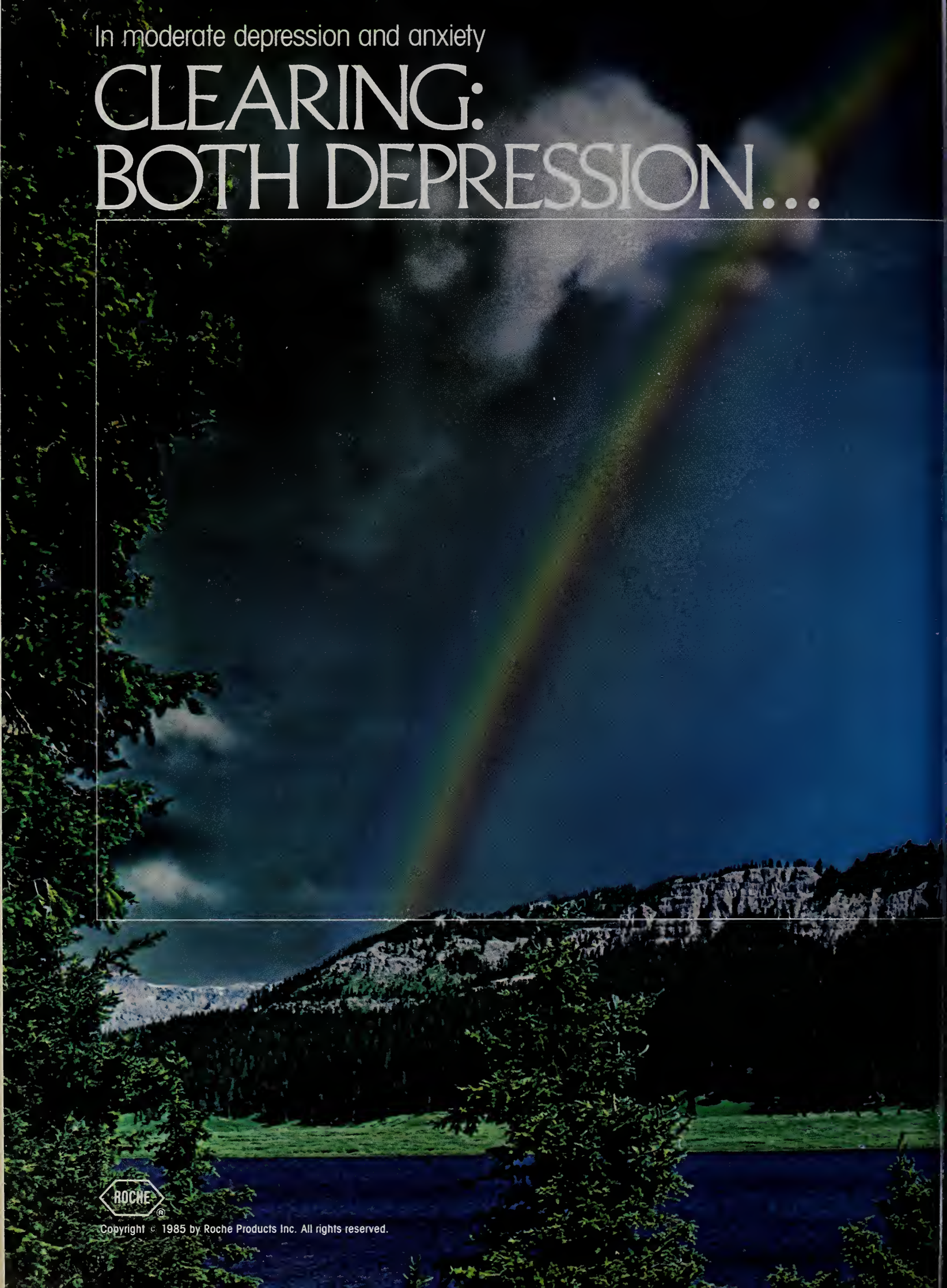


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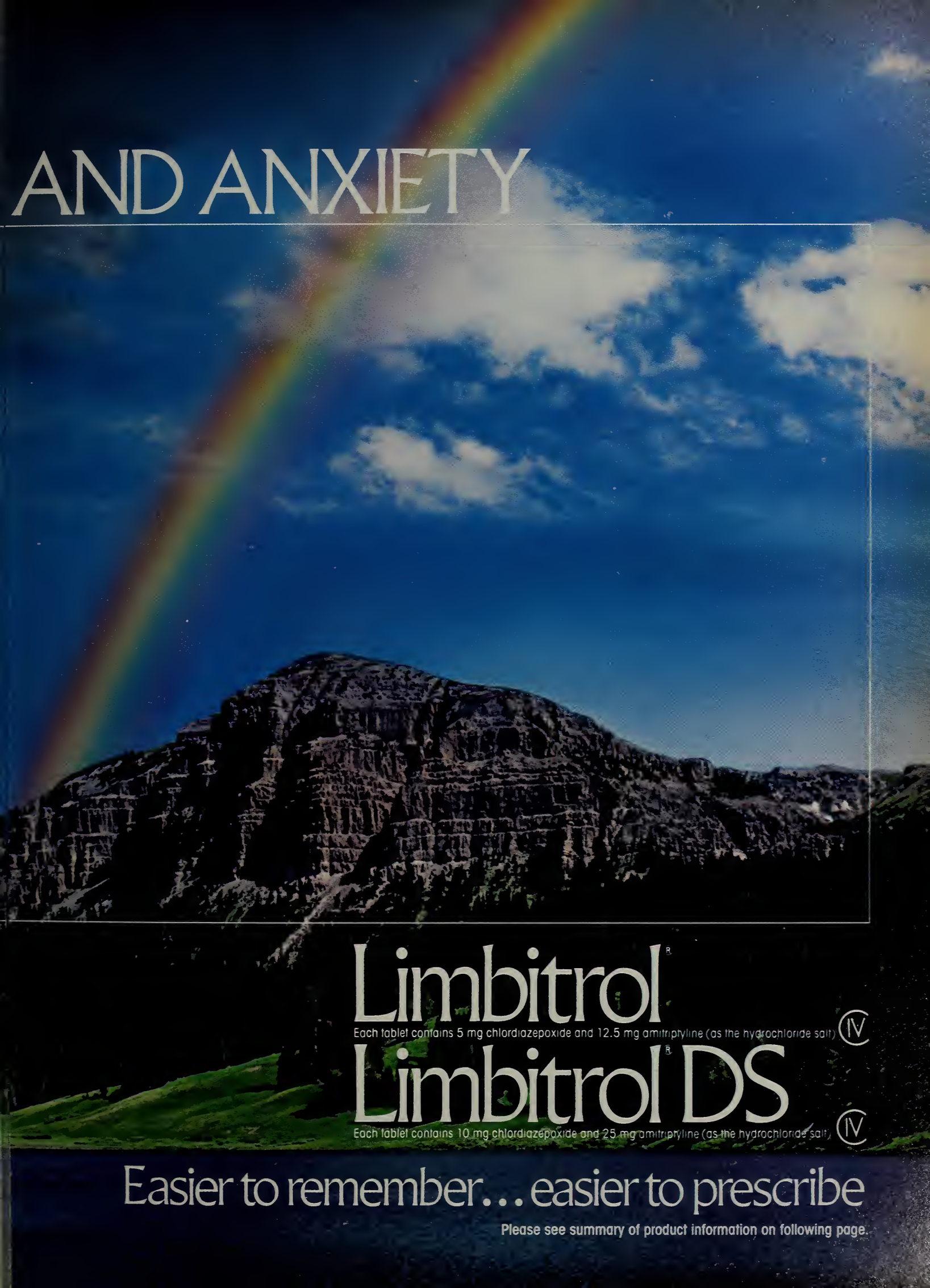
In moderate depression and anxiety

CLEARING: BOTH DEPRESSION...



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AND ANXIETY
Limbitrol®
Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (IV)
Limbitrol® DS
Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (IV)
Easier to remember... easier to prescribe
Please see summary of product information on following page.

LIMBITROL® (N) Tranquilizer-Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation at conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libida.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
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John E. Albers, MD

John E. Albers — OSMA's New President

Editor's note: *Normally this page would carry a message to you from OSMA President John E. Albers, MD. However, this month, we are breaking tradition slightly by telling you something about Dr. Albers himself — who he is, how he became involved with organized medicine, what issues he thinks will be important in the year ahead, and, as the newly installed President of the OSMA, what goals he may have set for himself, as well as for this Association. For many of you, this will be your first glimpse of the man who will be addressing you in this space in the future. For others, it will be yet another glance at a friend and a colleague whose tireless dedication and service to organized medicine has set an example for others to follow.*

Last month, a Cincinnati thoracic/cardiovascular surgeon by the name of John E. Albers, MD, stepped into the office of President of the Ohio State Medical Association.

The office of President is not unfamiliar to this 1955 graduate of the University of Cincinnati College of Medicine. Despite a busy surgical practice, and raising nine children with his wife Cathie, Dr. Albers found time to serve as president for both the Cincinnati Academy of Medicine and for the Mid-West Foundation for Medical Care. And certainly his activity in organized medicine — at the state, local and national level — has qualified him for the position he assumed during the OSMA's Annual Meeting, held this past May.

"I became involved in organized medicine by volunteering to serve on the legislative committee of the local Academy," he recalls.

That position sparked in him an interest which led to work on other committees, including service as a delegate to the AMA in 1978, and six years on the AMA's Council on Continuing Physician Education.

His work in continuing medical education has continued, too, on the state level. For three years, Dr. Albers chaired the OSMA's Committee on Continuing Physician Education — but his activity on the state level hardly ceases there. He has served as First

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Presidential Perspectives . . . *continued*

District Councilor to the OSMA since 1979, and his initial interest in legislative activities is reflected in both his past work as a member of OSMA's Legislative Committee, as well as his previous position as a board member of the Ohio Medical Political Action Committee (OMPAC). He also serves as a board member of American Physicians Life, a subsidiary company of PICO and on the PICO Board.

Regarding his new position, Dr. Albers says: "I have an obligation to the profession — to leave behind a legacy for those who follow," he says.

He admits that medicine will be faced with challenges in the year ahead, and points specifically to the liability crisis which has been steadily building force over the last year.

But his goals for the Association are both far-reaching and encompassing.

"We need to work on the preservation of physician independence, so that physicians can remain in control of health care," he says. As he points out, both industry and hospitals are currently vying for this control, and, with each succeeding year, they seem to gain a larger portion.

"Medicine has to present a united front against this kind of activity," says Dr. Albers.

Although he is, himself, a specialist, and involved in numerous specialty societies, including the American College of Surgeons, and the American College of Cardiology, Dr. Albers stresses that physicians need to see themselves as "physicians first and specialists second," if their efforts to maintain control are to be successful.

He believes that, ultimately, organized medicine may be the force that will accomplish what thousands of physicians, working individually, would fail to do.

"Almost everything that goes on today in health care is affected by organized medicine," he says. "We either generate the issues, or we try to protect our members from issues that have been generated by other sources."

Physicians who refuse to take a part in this process — who stay away from organized medicine — will not be able to do so for long, Dr. Albers believes. Given the current socioeconomic climate surrounding health care, he says organized medicine will be playing a stronger and stronger role in determining medicine's future course.

As a state association, it's reassuring to know that as organized medicine heads down this course, gaining in strength, numbers and power, that there are experienced and dedicated physicians like John E. Albers, MD, who are willing to take the helm. — *Karen S. Edwards*

Next month, watch for Dr. Albers's "Presidential Perspectives."

Colleague in the News

JAMES TENNENBAUM, MD, clinical professor of medicine, Head Section of Allergy at the Ohio State University Medical School, has been elected vice president of the American Association of Clinical Immunology and Allergy. Dr. Tennenbaum has been reappointed as Associate Editor of the Immunology and Allergy Practice Journal and has been elected to the Board of Directors of the Joint Council of Allergy and Immunology.

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Life and Death

Life is finite, and perhaps no one realizes this better than physicians.

They know that no one — no matter how advanced his or her medical knowledge may be — and no thing — no matter how technologically sophisticated it might be — can save man from the fate that has been his since eternity. As one cynic once wisely noted: "We don't even stand a 50-50 chance of getting out of this world alive."

This issue, the *Journal* takes a look at the terminal patient — not with any morbid thoughts in mind, but because death and dying is a part of the profession, as natural (if undesirable) as rejection is to a salesman.

Our lead article deals with hospices, and how the hospice concept is faring in Ohio. Should you refer your terminal patients to one? This article may help you decide.

A second article deals with the financial side of the long-term terminally ill patient. Who pays the bill for the hospice patient, the nursing home patient, the patient with home-health care? Several proposals to supplement insufficient public funding are currently in the works. You should know about them — and make your patients aware of them.

Since we've covered the ethical side of death in other issues of the *Journal,* we deliberately omitted the theme from this issue . . . with two exceptions.

The first is an article, submitted almost a year ago by Dr. Daniel Schubert, a psychiatrist at Cleveland Metropolitan General Hospital. His overview of how his hospital decided to handle the sensitive subject of "Do Not Resuscitate" is one we think will be of interest to every physician who has wrestled with this issue. We apologize to Dr. Schubert for holding his article so long, but we felt it would be most appropriate for this issue, and we think you'll agree that it's worth the wait.

The second is an article written by our Editorial Assistant Deborah Athy, which takes a subjective look at death by physicians who come in contact with it, perhaps more regularly than others. They tell you how they help their patients come to terms with their deaths — and how they handle their patient's death. And if you're still unsure as to whether or not you belong at your patient's funeral, maybe this article will help you decide.

Keeping in line with our new "mixed content" philosophy, you'll find a grab-bag of topics this month. We continue our series on malpractice by taking a look at its history here in Ohio, and how Ohio malpractice is developing during this present liability crisis. Also, you'll find the AMA's "AIDS action plan" included in this issue, so you'll know what kind of educational efforts are (or will soon be) underway on a national level. And you won't want to miss the *Journal*'s first book review, submitted by psychiatrist James R. Hodge, MD.

After all, although life *is* finite, it somehow always manages to go right on. Could we do less? — *Karen S. Edwards*

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Letters to the Editor

Hospital advertising

To the Editor:

High profile hospital advertising has turned into a hydra-headed monster. It devours health care dollars and proliferates with abandon, while boring the public with the familiar message that quality health care is available at local and regional medical centers.

The cost of this sad spectacle defies precise calculations. But it takes little effort to imagine the cumulative outlay for repeated TV commercials, full page ads in magazines and newspapers, eye-catching billboards, high gloss mailings, and sophisticated PR tactics. A rough statewide estimate for the current year would be a hundred million dollars, and it is being passed on to the public via high room rates.

At a time when state and federal legislators, businessmen, union leaders, health planners, and physicians are making concerted efforts to contain mushrooming health care costs, and when cost considerations are severely impacting the care of the elderly, wasteful spending by hospitals is unacceptable.

The public simply does not need to know that a trauma or stroke victim needs to be taken to an emergency department, or that open heart surgery is competently performed at certain hospitals, or that comprehensive diabetic care is now available, or that eye operations are skillfully done on both sides of town. The word is already out on these matters.

What the public needs to know is that hospital charges are tightly geared to quality care and not to Madison Avenue type.

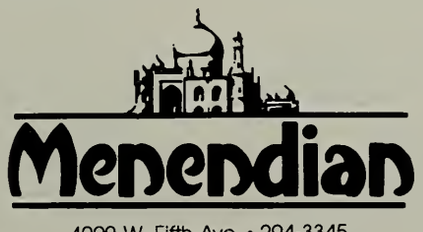
If hospital administrators cannot get together and quietly put a stop to the current media blitz, external controls of some sort will have to be imposed. A state regulatory agency for hospitals, as proposed last year by former Ohio Health Chief, Dr. David Jackson, is one solution to the problem. Penalties for high profile advertising, imposed by third payers or the Medicare reimbursement system, is another. State legislative hearings, as a starting point, is another.

The point is that something needs to be done to restrain this vocal and voracious creature called hospital advertising. It is time to stop bragging and get on with the job of taking care of sick patients.

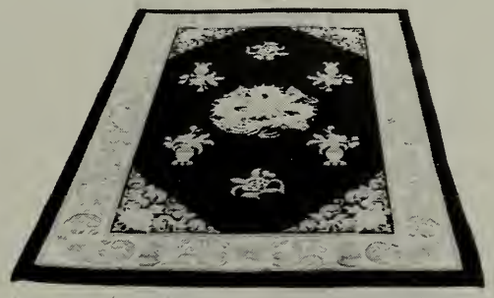
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Second Opinion

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What We Can Do to Stop Drunk Drivers

By William H. Havener, MD

We, all the citizens of Ohio, have already accomplished the first step in correcting the problem of drunken driving. We have legally defined drunken driving as being a blood level of 0.1% or greater of alcohol in a driver.

Unfortunately, this hasn't corrected the problem. Recently, three persons were killed in Columbus when their vehicle was struck from behind by a speeder who refused a test for alcohol. Another time the *Dispatch* reported a home was demolished when struck by a vehicle at 3 am. The driver fled the scene. One can reasonably presume such behavior on Saturday night is not characteristic of a sober person.

Obviously, it is now time to take the second step, the enactment of an effective deterrent penalty. We can assume that the answer will not be found in any of the existing types of law, since none of these statutes have been effective. Jail, fines, judge, and jury have all failed us and can be discarded as not useful tools.

Detailed explanation of why these approaches have not worked would excessively prolong this essay. Better to define what will work. A solution with any hope of success must have the following features:

1. automatic, administrative implementation that the potential drunken driver knows will certainly occur;
2. unequivocal and immediate separation of the offender from his vehicle. Taking away the driver's license doesn't work. Access to a vehicle must be denied. One can't drive drunk without a vehicle to drive;
3. a penalty that does not cost society for its enforcement. The cost must be borne by the offender, which is entirely appropriate and proper. Jail is too expensive, too crowded, and doesn't stop the individual from getting drunk again as soon as release occurs;
4. replacement of the concept of punishment by an approach of prevention. We must prevent the drunk from driving again by removing his capability of driving for a prolonged period;
5. recognition that the victims of drunken driving are more important than the convenience of the offender. If the penalty is inconvenient to the offender, well, that's too bad — that is the intent of society for the purpose of self protection.

Following is a proposal that embodies all these principles. All Ohio needs to do to eliminate drunken driving is to revoke the *vehicle* registration plates automatically and immediately upon detection of a drunken driver or a driver whose driver's license is under suspension for previous drunken driving.

Within two months of enactment and enforcement of such a statute, Ohio will cut its drunken driving tragedies by at least 90 percent.

"Hardly an adult in Ohio does not have a friend or relative who has suffered a terrible loss to a drunken driver."

Upon hearing this proposal, many considerate persons first say, "Gracious, how inconvenient that would be for the drunk. We couldn't be so mean to the poor soul." Well! How about the victims — 25,000 of whom lose their lives, who are maimed and disfigured for life, who suffer $50 billion in property damage each year — where is the balance between their tragedy and the drunk's inconvenience of no vehicle for a month?

Physicians of the state of Ohio, you have the power to endorse this proposal and to lead the great majority of Ohio's citizens in their active support for an effective remedy to the ridiculous curse of drunken driving. We are ready and waiting to act. Hardly an adult in Ohio does not have a friend or relative who has suffered a terrible loss to a drunken driver. That is why MADD has succeeded far beyond any reasonable expectations. We are only a handful of concerned individuals, but we are the voice of the victims.

Please be our leaders. Thank you!

Proposed Ohio model law to eliminate drunken driving

"Administratively effected recall of both the driver's license and the license plates of the vehicle shall be the penalty for driving 1) under the influence of 0.1% or greater of alcohol or 2) when impaired by other drugs or 3) during a period when the driver's license has been lost for the offense of driving under the influence of alcohol or other drugs.

Existing jail and fine penalties for driving under the influence of alcohol or other drugs are hereby repealed. Penalties for other offenses than being under the influence are not changed by this legislation. No civil liabilities are voided by this legislation."

Explanation of the Basis for this Proposal

1) Immediate administratively effected removal of the vehicle license plates is a certain penalty that will prevent the offender from driving that particular vehicle during the penalty period.

2) The provision for immediate vehicle license plate loss as a penalty for driving with a suspended license will effectively deny use of any vehicle to the repeat offender.

3) Unlike present law, this proposal will place the cost of the penalty upon the offender rather than upon society. Presently, our jails contain drunken drivers, at a high cost to maintain them incarcerated.

An even more serious cost to society is the breakdown of our system of justice, which is clogged with endless numbers of drunken driving cases. Removal of all these unnecessary cases will permit timely function of our courts. The impact of this upon our society can hardly be exaggerated!

It is folly for society to waste its own money and time to punish these offenders. Let them pay the costs of money and inconvenience they have incurred by their misbehavior.

4) Is it too harsh a penalty to suspend the license plates of a vehicle used by a drunken driver? To inconvenience the family? This judgment must be weighed against the alternate penalty — the deaths, injuries, and property destruction inflicted upon the innocent victims of the drunken driver. If society does not choose to penalize the drunken driver so heavily as to eliminate him, society has chosen to penalize innocent children and adults. Only two alternatives exist: 1) Penalize the drunken driver today by cutting off his wheels or 2) penalize the innocent victim tomorrow by killing and maiming and property destruction.

5) Prompt medical evaluation of the impaired driver is appropriate. Intoxication is dangerous; indeed, it may be fatal. Other problems may be mistaken for intoxication, for example, insulin overdosage, cerebral diseases, or brain injury from an accident.

Also, drunken drivers are five times more likely to die in an accident than are sober drivers (because they have more accidents). The life saved may be their own.

Proposed details of the Ohio Model Law

1) Upon detection of an impaired driver by a law officer, the officer will do the following actions:
   - A) Transport the impaired driver to an emergency room for medical evaluation and care (at present he is taken to a police station).
   - B) Arrange for towing of the vehicle to impoundment (presently happens).
   - C) Obtain both the driver's license and the vehicle

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"Drunken drivers are five times more likely to die than sober drivers . . . the life they save may be their own."

license plates, to be delivered to the Bureau of Motor Vehicles.

D) File a relatively brief report summarizing the details of who, when, where, what.

E) The officer does not have to waste his time at future trials, because there will be none for the offense of drunken driving.

2) Upon delivery to the emergency room the driver will have the following choices:

A) Behave in an unruly fashion, requiring transfer to jail.

B) Request medical evaluation, including a blood test for alcohol.

C) Deny performance of a medical evaluation and/or blood test.

3) The emergency room receiving an impaired driver shall have no legal obligation to the driver, unless the driver voluntarily requests the services of the medical facility. The driver will be informed by the law officer that the recalled licenses will be returned if the blood tests and medical evaluation invalidate the suspicion of impaired driving. The options available at the emergency room will be:

A) Immediate transfer to a police station if the driver's behavior is uncontrollably inebriated and medical evaluation and/or blood testing is refused.

B) Medical evaluation and drawing of a blood test for alcohol, followed by transfer to a police station, via the law officer.

C) Hospitalization, if this is determined to be medically appropriate.

4) Upon receipt of the driver's license and vehicle license plates, the Bureau of Motor Vehicles shall revoke them for the prescribed length of time, which will be for the vehicle plates 1 month for a first violation, 3 months for a second violation by the same individual, and 6 months for all subsequent violations by the same individual. The length of time for revoking the driver's license will be 1 month for a first violation, 6 months for a second violation, and 2 years for a third violation. For return of the licenses, a fee will be assessed, of an amount estimated to be at least the actual total cost of processing such transactions plus $100 (to be used to pay for emergency room charges and other costs to the state). The licenses will be returned promptly at no charge if:

A) The driver has permitted the emergency room to draw promptly a blood test that measures less than 0.1% alcohol *AND* the emergency room physician has determined that the driver does not seem to be under the influence of any drugs (including alcohol).

B) The vehicle has been stolen. The owner of a vehicle claimed to be stolen shall execute a sworn, notarized statement that the vehicle has been stolen and that the owner promises to testify to the fact of theft at any future trial.

5) Upon payment of the assessed fees for towing and storage, the impoundment facility shall release the unlicensed vehicle to be towed away by the owner. Since it will not have license plates, the vehicle may not be released to be driven away.

6) The police station receiving an impaired driver shall establish positive identification of the individual, including fingerprinting. The driver will remain in protective custody so long as the impaired condition requires. Release may be to the care of responsible friends or relatives, or to the individual when the effects of the impairing drugs have disappeared and normal judgment has returned.

This legislation repeals any mandatory duration of jail time for the specific offense of driving under the influence of alcohol or drugs. The penalties for any other offenses or charges shall not be changed by this legislation, nor shall it exempt the driver from liabilities related to his actions.

7) In the apprehension of a driver operating a motor vehicle during the period of time when the driver's license has been suspended, any law officer may use any information obtained from any source to detect the offender. The detection may also be effected by the actions of the law officer.

Upon apprehension of a driver operating a vehicle during a period of driver's license suspension, the law officer will arrange for towing

continued on page 381

News Digest

Edited by Deborah Athy



Beware the youthful "dieting" patient

Beware the next time one of your high-school age patients mentions the need to lose weight.

A new study, conducted by a Stanford University medical school psychologist, found that one in eight high school sophomores will try to lose weight by vomiting or using laxatives or other drugs — although few of them would be classified as true bulimics.

"What's alarming is that, at age 15, we see kids beginning to use some of these unhealthy weight-regulation strategies which, if unchecked, may develop into full-blown eating disorders," says the researcher in a recent issue of the *Journal of the American Medical Association.*

Susan C. Wooley, co-director of a Cincinnati eating disorders clinic, agrees that the findings are alarming, and that "parents, teachers and doctors should be aware of it and vigilant."

The *JAMA* article goes on to say that "a lot of physicians may not be aware of the extent of purging in teen-agers." Although twice as many girls as boys used purging, Wooley said the proportion of males in the study was surprisingly high, considering most studies have shown that eating disorders overwhelmingly afflicted females.

"It's important if they (doctors) are going to work with adolescents on weight control to focus on healthy eating and increasing physical activity," says the article.

School health classes which include information on eating disorders were also recommended.

Health care in absentia

What's a mom and dad to do when their child is sick — not seriously ill, just a bad case of the sniffles — and neither one can afford the time off work to stay home with junior?

A "sniffle center" may be just what today's parents are looking for — someplace where mom and dad can drop off a sick youngster, confident in the fact that he or she will be well taken care of, and then return that evening to pick up the child. In a society teeming with more and more single-parent households and households where both parents work, the idea is catching on, and "sniffle centers" are beginning to pop up all over the country — at last count, amounting to some three dozen, with every indication that more facilities are on the way.

One such facility hires nurses to take care of the sick children, and each day they report to the parents the status of their child's health, what his or her temperature has been through the day, etc. Another center places children in separate rooms according to illness — colds and coughs, stomach aches, and chicken pox.

The toothbrush/sore throat connection

The next time a patient comes into your office with complaints of a continuous sore throat, tell them to pitch their toothbrush.

That's the advice of Tom Glass, MD, chairman of oral pathology at the Oklahoma University School of Dentistry, who believes that bacteria on patients' toothbrushes may be the culprit behind lingering sore throats and other infections.

According to Dr. Glass, "It looks like it takes 17 to 35 days to heavily infect a toothbrush," so he recommends patients use a new toothbrush every month.

a compilation of the latest developments, reports and products of interest to physicians.



Physician surplus now estimated to be greater

The physician surplus in the future could be 50 percent *greater* than originally estimated by the Graduate Medical Education National Advisory Council (GMENAC), according to a recent study published in the *New England Journal of Medicine.*

GMENAC based its estimates on the number of physicians staffed in fee-for-service settings and did not take into account the recent growth in HMOs, the study reports. HMOs use fewer physicians and tend to rely more heavily on nurse practitioners and physician assistants than fee-for-service practices do, the study continues.

This finding seems especially pertinent in light of the fact that HMO enrollment has tripled in the past decade, and, according to health care analysts, shows little sign of easing up.

Financial health-care notes

***Columbus workers willing to share health costs with employers**

Fifty-three percent of the workers responding to a Louis Harris and Associates study, conducted in Columbus, said increases in their insurance premiums and other additional costs were acceptable, but only 48 percent approved of increases in deductibles or copayments and few shared any enthusiasm for increased out-of-pocket expenses.

According to Charles Turner III, Director of the Coalition for Cost Effective Health Services, Columbus businesses trail the rest of the nation in converting to health maintenance organizations, but probably take the lead in requiring employees to pay increased deductibles and getting second opinions.

"The great majority of companies have instituted these kinds of measures," Turner says, adding that workers in Columbus are apparently accepting the changes.

***Medicare fund continues to flounder**

The federal trust fund which pays for Medicare's hospital insurance is in more trouble than was believed earlier, and Congress should take "early remedial measures" to prevent bankruptcy in the mid-1990s, the funds trustees said in its annual report to Congress.

The report states that the current Medicare income is "barely sufficient" to pay benefits and maintain the trust fund at the recommended reserve level, which covers six-month payments over the next seven to nine years.

"Even though the trust fund is expected to be able to pay benefits and administrative expenses as they become due until the late 1990s, any significant adverse deviation from these projections could result in the inability of the fund to meet its obligations much sooner than expected," the report says.

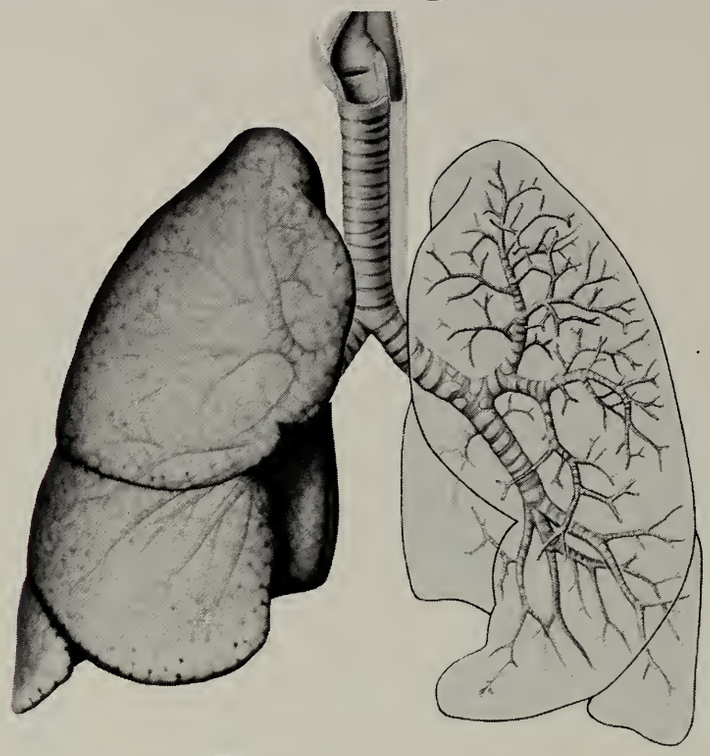
Medicare's new prospective payment system already has proven effective in controlling the growth of hospital spending, the report continues, adding that similar efforts need to be continued.

In other reports, the trustees said the Medicare supplementary medical insurance trust fund, which pays doctor bills and other medical expenses under so-called "Part B" Medicare coverage, is financially sound.

However, the board said it "notes with concern the rapid growth in the cost of the program," and recommended that Congress take action to curb the rising cost.

Trustees also gave a clean bill of health to the old age, survivors, and disability insurance trust funds, saying they will be able to pay benefits on time "for many years into the future" under even the most pessimistic economic assumptions.

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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

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- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

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Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%, usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

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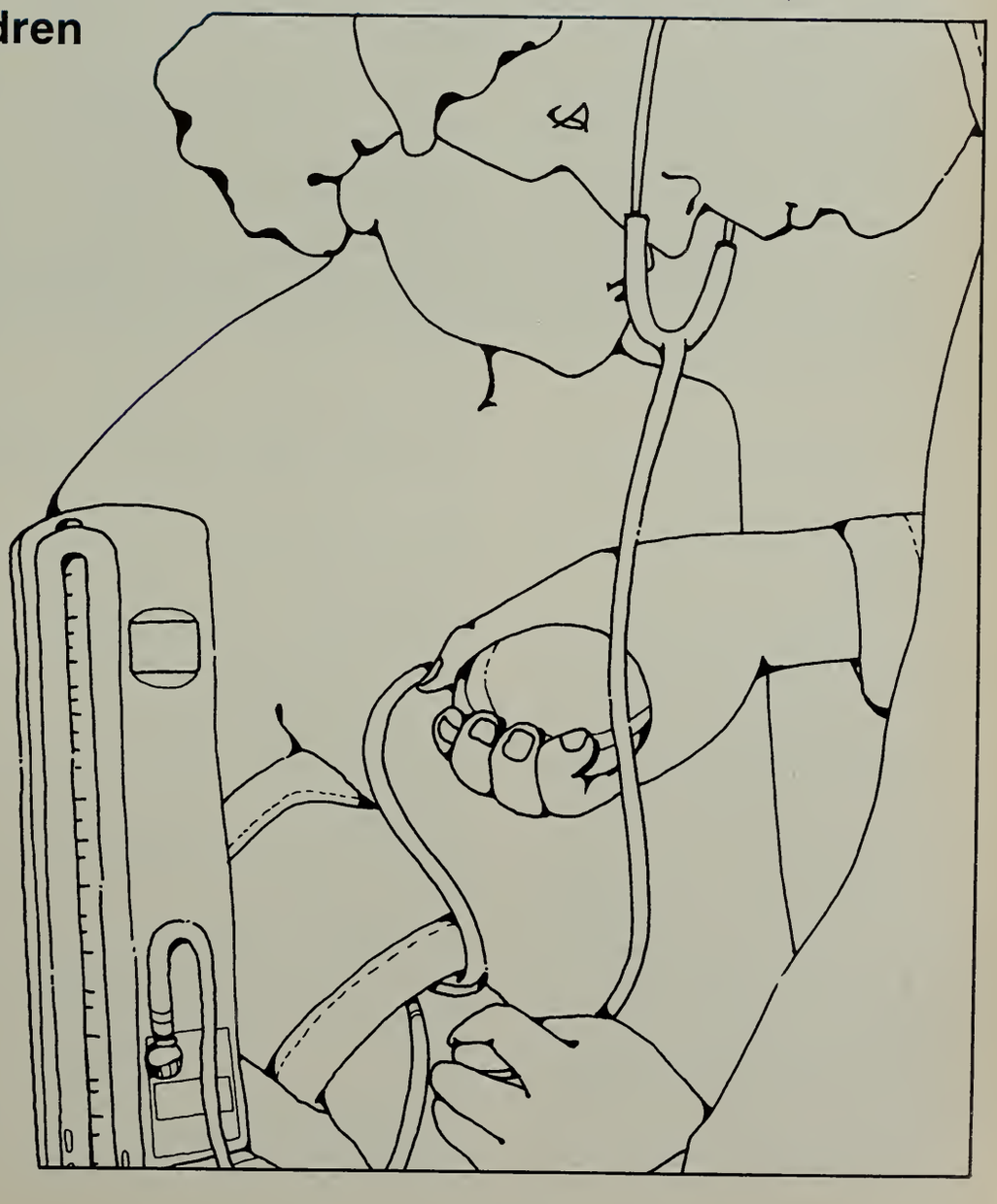
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Ohio medi-scene

Blood pressure and children . . . art and abuse . . . new parcourse for disabled . . . genetic markers for heart disease

Hypertension in children



For years many people believed that high blood pressure was strictly an "adult" condition, and, if it occurred in children at all, it was the result of some other problem such as kidney or heart failure, says Philip Walson, MD, a pediatrician and clinical pharmacologist from Columbus.

Hypertension *was* a rarity in children because, for the most part, no one took blood pressure readings of children as part of their regular examinations unless other symptoms were present, Dr. Walson says. In other words, "If you don't measure it, you don't find it."

Through his studies in pediatrics and hypertension, Dr. Walson has found that "if you measure the blood pressure of every child, and you do it correctly, you find high blood pressure is neither rare nor necessarily caused by some other kind of illness."

The American Academy of Pediatrics has recommended for at least 15 years that blood pressure readings should be measured regularly for children beginning at age three, Dr. Walson points out. But, over the years, this advice has gone largely unheeded, he says. "Blood pressure measuring

Ohio medi-scene . . . continued

Hypertension in children . . . *continued*

in children is kind of a lost art."

This explains why Dr. Walson, with help from the American Heart Association, helped pave the way for the Pediatric Hypertension Program at Children's Hospital in Columbus. The program serves a dual purpose by offering a blood pressure training program for health care professionals and by serving as a clinic where children can be evaluated for hypertension.

Approximately 1,000 health care professionals have completed the blood pressure training, according to Patty Graves, a hypertension nurse who works in the program. "We really want to emphasize the importance of taking regular blood pressure readings for children," she says.

The training also focuses on the *proper* techniques and equipment that should be used when measuring a child's reading.

Equipment

One of the most important factors in getting an accurate reading is the proper cuff size of the sphygmomanometer, says Dr. Walson. And that doesn't mean automatically using a child's cuff. The cuff size should be directly related to the size of the child's arm, he explains.

More specifically, "the bladder width should be 40% of the upper arm circumference as opposed to two-thirds of the upper arm," which is considered the "norm," Graves adds. This is often one of the most frequent mistakes, she points out.

In addition, the equipment must always be in sound working order, says Dr. Walson. Test periodically to make sure the measuring device is properly calibrated; if it's not, the accuracy of the reading is at stake.

Techniques

The techniques which should be used for measuring blood pressure in children vary from those used for adults. For example, pressure in the cuff should be pumped up 20 to 30 millimeters above the normal systolic pressure for children (from 100 mm. to 120 mm. for children, as compared to 120 mm. to 240 mm. for adults).

And, whereas the blood pressure in adults is recorded at phase I (when the sound of the pulse appears) and phase V (when the pulse disappears), the American Heart Association also recommends recording phase IV, when the sound of the pulse begins to be muffled, for a more accurate reading for children.

The pressure in the cuff should also be deflated at a slower rate — two to three millimeters per second or per heart beat — so that phase IV and V can be differentiated more easily, Dr. Walson suggests.

Health care professionals must make sure to base high blood pressure referrals on a hypertension range tailored specifically for children. For example, while 120/80 is not high for an adult, it is considered very high for a 2 year old, he points out.

In addition, keep in mind that external factors such as decongestants and nosedrops may affect the accuracy of the reading.

Child Psychology

The ability to work well with children is a real plus, according to Dr. Walson. All in all, a reading will be easier to take and more accurate if the child feels comfortable and relaxed, he predicts.

"Avoid the use of the word blood," he suggests. "Children tend to tense up if you say, 'I'm going to take your blood pressure' "; they may think you're going to take a blood sample, he explains. It may be better to say, "I'm going to listen to your heart," he suggests.

Public awareness of hypertension in children is improving, Dr. Walson says. But it's detrimental to enhance the public's awareness of hypertension with scare tactics such as past advertisements which have depicted people who have high blood pressure with bombs ticking on their chests. For a child who has been diagnosed with high blood pressure, that's a frightening image, he explains.

There's good evidence that hypertension has its roots in childhood, Dr. Walson says. Early detection would not only help prevent future illnesses, but would also be more cost-effective, he continues. But, he adds, blood pressure readings "shouldn't be done as a mass screening, but should be part of a child's regular physical checkup."

— Deborah Athy



Art and abuse. Can one reveal the other?

On the surface, the child's drawing of a bright blue house with an appletree and blooming flowers in the yard suggests a carefree and cheerful disposition.

But there may be more there than meets the eye, according to Wright State University professors of art therapy, Lewis Shupe and Gary Barlow.

"We feel there are certain things within the artwork that could be indicators of incest or abuse; we call them 'visual markers,' " Shupe explains in a recent article in the Columbus *Dispatch*.

For example, in the drawing mentioned above, the child had depicted herself in the picture as a small, brightly colored figure that could easily be mistaken for another flower.

"She almost disappears into the drawing," Shupe points out. For this reason, Shupe and Barlow believe the drawing reveals a lack of self confidence, a withdrawal from family, and the possibility of incest.

The researchers have examined the artwork of about 135 Ohio children — some who are known victims of abuse — for reoccurring patterns which may indicate signs of abuse.

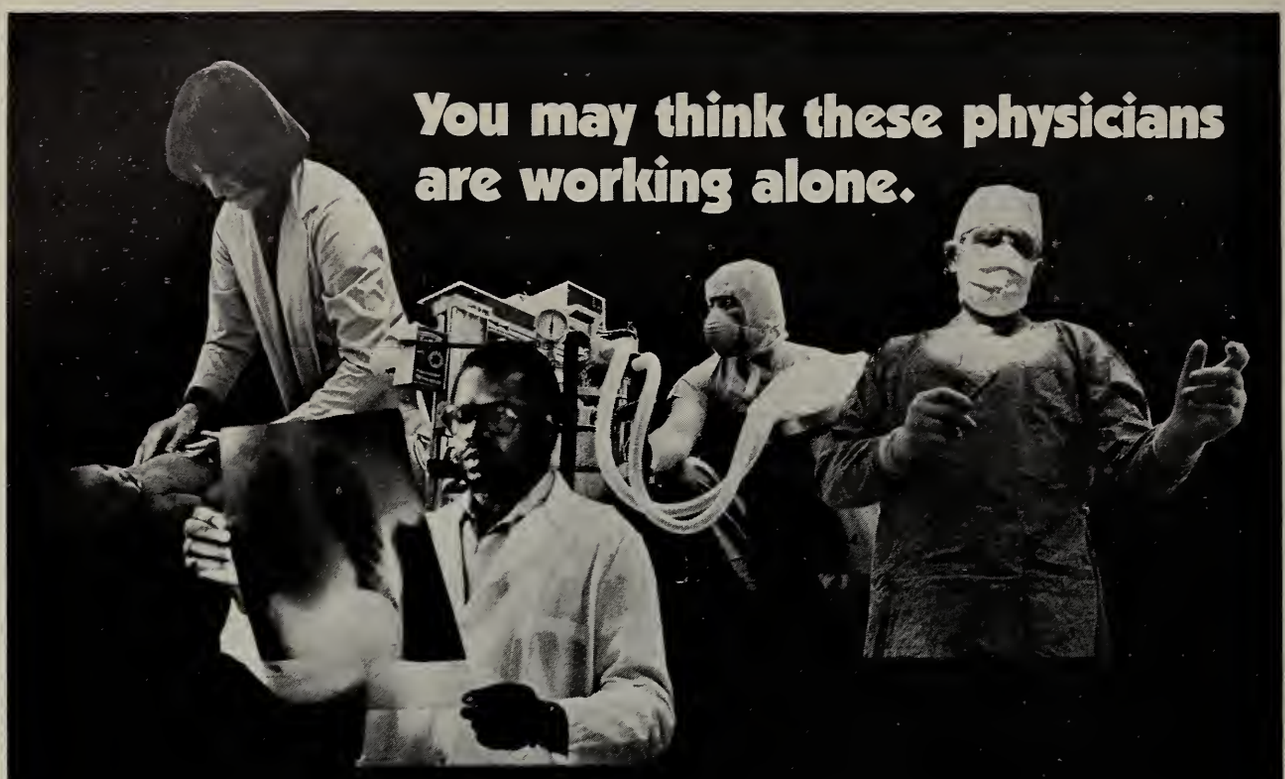
One child drew a family grouping in which the people lacked mouths; a sign, the researchers suggest, that the family was unable to talk about a hidden problem.

But Shupe and Barlow are wary about unnecessarily alarming parents with their research because some "visual markers" tend to be common among many children. For example, the use of the color red for a house fits a pattern used by abused children, but not every child who colors a house red has been abused.

"It's how they draw as well as what it is they draw," Shupe points out, adding that he and Barlow examine several samples of a child's work before reaching any conclusions.

Although their study is still in its embryonic stage, the researchers feel strongly that sometimes "children can express something symbolically in their artwork better than they can express it in words."

— *Deborah Athy*



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Ohio medi-scene . . . continued

New parcourse for the physically disabled

Physicians in Columbus now have someplace to send handicapped patients who wish to remain physically-fit — despite their disability.

A parcourse for the handicapped, dedicated this past fall, is probably the only one of its kind in the state, says Marjorie Clark, supervisor of the Orthopedically Handicapped Program in the Columbus Public Schools.

"We know there are courses like it in Indiana and Florida, but we don't know of anything like it in the state," she says in an article that ran in the NeighborNews section of the Columbus *Dispatch*.

The course, located beside Colerain Elementary School, is specifically for those who have some upper body strength, but are unable to walk. It was designed following recommendations from both the American Medical Association and a committee of wheelchair olympians, and was built with grants from Children's and Grant Hospitals and from donations to the Locker-Britt fund for Colerain.

One of the best features about the course, says Clark, is that it was especially designed for the physically disabled, and was not simply modified or adapted for their use.

Course participants follow directions, given in both words and pictures, at each of ten stations. Exercises include warm-up activities (the first two stops), workout activities for cardiovascular strength (stations 3-8), and cooling down exercises at the course's last two stations.

Although the parcourse will be incorporated into Colerain's orthopedically-handicapped program — which provides education to students from a seven-county area — any person who is confined to a wheelchair, yet possesses some upper-body strength, is welcome to use the new parcourse on weekends and/or weekday evenings. Little, if any, assistance is needed, so all ages — from 7 to 70 — will find it manageable. Still, Clark warns would-be participants not to *overdo* it." — *Karen S. Edwards*



Genetic marker found for heart disease

A new blood test may enable physicians to determine which infants are more likely to develop heart disease as adults, according to a recent study published in the *Cincinnati Enquirer*.

Researchers involved in the study have found that some people inherit a tendency to produce low levels of high density lipoproteins and, consequently, are at higher risk of heart attacks.

This is "the first time we have identified a specific *genetic marker* that allows diagnosis of people at high risk for inherited heart disease," says Charles Glueck, MD, director of the University of Cincinnati Lipid Research Center.

In addition, once an infant has been diagnosed as having a predisposition to heart disease, a special diet and exercise regimen can be prescribed to prevent the disease from developing, the article points out.

If you wish to contribute material for Ohio medi-scene, or to submit an idea, please contact the Executive Editor, the Ohio State Medical Journal, 600 S. High St., Cols., OH 43215.



Hospice —
New Hope for the Terminally Ill

By Susan Porter

The room is dark and quiet. Family photos, flowers, plants, cards and a few carefully selected mementos line the top of a small bureau. The patient rests at an angle, propped up on several pillows so that he can watch the birds which frequently perch outside his window. At the moment, however, his eyes are closed and he is sleeping comfortably, his calm face belying the torture he suffers from the cancer ravaging his body.

The man is terminally ill, but there are no respirators, CPR equipment, IVs or other life support systems at hand in this isolated hospital facility. No tubes have been inserted into his nose, arms or stomach, nor have fresh blood supplies been reserved for his use.

Outside the room in a well-lit hallway, the patient's wife is making arrangements to take her husband home again, while a staff member reviews with her the many and demanding day-to-day needs of the dying patient. At the top of the list is the name and phone number of hospice team members available for consultation 24 hours a day, seven days a week. A physician, nurse, social worker, clergyman and a host of volunteers all are at their disposal, helping this couple get through the most painful ordeal of their lives — as painlessly as possible.

"There Are Some Things That No One Should Have To Face Alone . . ." says the literature describing Hospice of Cincinnati, Inc., one of more than 40 active hospice programs in Ohio and the oldest in the state. But unfortunately, says James M. Hall, MD, medical director of Hospice of Cincinnati, Inc., and one of its three physician founders, too many dying patients and their families have been neglected in the past in the traditional health care system.

Like other oncologists and hemotologists across the state, Dr. Hall was frequently faced with the prospect of having to tell a patient, "There is nothing more we can do for you." And too often, he says, those patients were shuffled and lost in the mainstream of other hospitalized patients in various stages of acute illness or injury.

"It was clear in treating cancer patients that often times when things were going badly — when treatment and therapy were not

"An individual in the process of dying doesn't want to be abandoned" — and yet it seemed that abandonment had occurred.

Hospice . . . New Hope

continued

going anywhere — the patient was not getting the kind of attention he or she really needed," Dr. Hall recalls. "By and large, they were kept on a general medical floor with patients suffering from conditions like pneumonia or heart failure" — treatable conditions that took all of the attention of the nurses on the floor. Since there was little medically that could be done for the terminal cancer patient, "we saw a good deal of unintentional neglect at a time when people needed our attention the most," he says. "An individual in the process of dying doesn't want to be abandoned" — and yet frequently it seemed to both the patient and the patient's family that abandonment had occurred.

Thus in 1977 — four years after the founding of the first United States hospice in New Haven, Connecticut — Hospice of Cincinnati, Inc. opened an outpatient program for dying patients and their families in the Greater Cincinnati area. "We are one of the only, if not the only hospice in this country founded entirely by physicians," says Dr. Hall.

Initially the Christ Hospital in Cincinnati supported the program with work space, seed money and a program coordinator, while a board of directors was selected from the community to organize the program financially. Later, an inpatient facility was sought, and so the hospice board approached Bethesda Hospital about the use of its old deaconess home on the hospital grounds.

"We wanted a building completely separate from a hospital for the program," Dr. Hall explains, "in order to keep the atmosphere different from the standard hospital setting. We have our own independent nursing staff and 24-hour visiting hours for patients' families," he says. "We also wanted to avoid the rush and fury of the normal hospital setting — orderlies pushing carts through the hallways, constant paging over the intercom, and so on."

Thus Cincinnati's inpatient hospice facility opened with 18 beds on Bethesda's grounds in April of 1981. Shortly thereafter — chiefly for financial and reimbursement purposes — Hospice of Cincinnati became a part of Bethesda's total operation, although the program and facility remain autonomous.

"Patients can bring their own personal possessions into their rooms," Dr. Hall explains, "and their families are welcome at all times. We have one nurse for every two or three patients, and we encourage them to spend as much time as possible sitting with and talking to patients and their families — something that would be almost unheard of in a normal hospital setting."

Still, Cincinnati's hospice patients spend only a brief time in the inpatient facility which is reserved exclusively for short periods of respite care and symptom management and control. About 80% of the dying patient's last days are spent at home, and almost half of Cincinnati's hospice patients die in their own beds. Like all hospices in the US, says Dr. Hall, the crux of the program is to help ensure quality home care for the dying.

"The purpose of hospice is to provide terminal patients with the option of remaining at home — to die at home in their own surroundings," says Warren L. Wheeler, MD, who founded Hospice at Riverside (Hospital) in Columbus. "We offer a medically oriented team approach to pain and symptom control," he continues, but the day-to-day care of the patient is provided in the home.

For this reason, a major prerequisite of being admitted to a hospice program is that the patient have a willing care giver in the home. That care giver can be a family member, a neighbor, a friend or a hired helper. He or she "doesn't have to be there 100% of the time, as long as there is always someone available," says Sharon L. Erel, MD, medical director of the Northwest Ohio Hospice Association. The working spouse or live-in family member can hire outside help or have someone come into the home on a part-time basis, she says. But while hospice staff members and volunteers will assist the care giver in learning to care for the dying patient, hospice does not provide 24-hour home care.

"The family must provide that half of the contribution," says Betty Schmoll, executive director of Hospice of Dayton, Inc., and the current treasurer of the Ohio Hospice Organization, an association of 42 active hospices in this state and 10 hospices still in the early formation stages. "Perhaps this is our biggest problem — we can't offer help to

"We feel the whole hospice program possibly and probably prevents morbidity in survivors."

those who don't already have a care giver," Schmoll adds.

What hospice does offer, however, are "professionals who have been carefully selected and prepared to work in the home setting," says Schmoll. These professionals — representing medicine, nursing, social services, psychology and religion — work in teams to aid dying patients and their families with the psychosocial aspects of their dilemma, as well as the physical ones. Team members will come into the home when needed and will help get the patient admitted for inpatient care when appropriate.

In addition to the work of the 40 paid staff members, Dayton's hospice program is heavily bolstered by the efforts of some 140 volunteers, who include everyone from a barber who makes home visits to cut or trim patients' hair to a clown who helps hospice families celebrate important occasions. Hospice volunteers run errands, provide transportation, prepare light meals, help with housework, and pick up prescriptions for patients and their families on a limited, as-needed basis. More importantly, they provide emotional support and aid, by visiting the patient and his/her care giver and lending a hand. Home care volunteers in Dayton will go to the home once a week and help give the patient a bath, change bed linens, or simply sit with the patient so the care giver can leave for a short period of time or take a nap for much needed rest.

While hospices vary across the state, most also require that the patient has a prognosis of six months or less to live, and that all attempts at therapy or treatment be completed. Patients still involved in an aggressive treatment program are not accepted; nor are those who are expected to live several years without treatment. Patients also must be referred to the hospice program by their physician.

Patients of all ages, including infants with congenital malformations, children and young adults have been cared for by hospices throughout the state. The majority of hospice patients, however, are over 65 and are thus able to take advantage of Medicare reimbursement for hospice care. The hospice benefit is an alternative to regular Medicare coverage and covers a wide variety of services not offered under the regular program. These include nursing care, medical social services, physicians' services, counseling, short-term inpatient care for symptom control, short-term respite care, medical appliances, supplies, medications, home health aide services, homemaker services, physical therapy, occupational therapy, speech therapy, dietary counseling, bereavement counseling, and 24-hour nursing coverage during short-term periods of crisis.

In addition, more and more insurance companies are reimbursing for hospice care, recognizing the cost effectiveness of this type of outpatient care which has no need for X-rays, lab tests or other expensive procedures. Those involved in hospice also believe the program provides long-term cost savings by helping family members — particularly spouses — through the process.

"Part and parcel of the whole dying process is the bereavement of the loved ones afterwards," says Dr. Erel, explaining most hospices offer a year of follow-up visits and consultation after the patient's death. "We feel the whole hospice program possibly and probably prevents morbidity in survivors, because it makes the process easier to go through and gives support when the family most needs it."

This support includes everything from helping the family to make funeral arrangements, to encouraging spouses to discuss often taboo subjects with the dying patient. "We may try to get a married couple to talk about establishing a will, disposal of clothing or even remarriage," says Dr. Wheeler. "Often these are never discussed with the dying patient, and, then, after his wife dies, the husband has no idea what to do with her clothes, or he feels guilty every time he looks at another woman."

All of this contrasts sharply with the traditional treatment of the family following death. In the standard hospital setting, "the patient dies, someone signs a piece of paper to get the body out, and that's it," says Dr. Hall. "The family may not see or hear from anybody after that point." In fact, the whole purpose of hospice, says Dr. Hall, is to involve the family in the care of the dying patient, and to make death as easy on the

The physician's medical education focuses on cures and successes — not on death and dying.

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continued

patient and the family as possible.

"We only die once," says Dr. Wheeler, "and most of us don't know how to do it. So we rely on the expertise of others who have a lot of experience with death. This is what hospice can give us."

What hospice patients don't get, however, are cardio-pulmonary resuscitation, respirators, IV therapy, radiation treatments, chemotherapy, surgery, naso-gastric and gastrostomy tubes for feeding purposes, or blood transfusions. Instead, all treatment is oriented towards the alleviation of pain and other symptoms, in order to make the patients' last days as comfortable as possible.

It is here that the hospice concept veers most dramatically from traditional medical care and where some physicians have problems accepting it for their patients. "We have a very traditional medical staff here," says one staff member at a hospice program sponsored by a Cleveland area hospital which has met with some resistance from local doctors. "The physician's medical education focuses on cures and successes — not on death and dying. When they lose the battle, they tend to take it personally. Also, many have not come to terms with their own feelings about death — and so it's very difficult for them to help someone else accept the fact that they're dying."

Doctors Hall and Erel agree. "It is heavily ingrained in the physician during education and training that you have to keep bailing out the ship until it finally sinks," says Dr. Hall. Thus bringing in respirators, life support and CPR are almost knee-jerk responses to a patient's final gasps.

"Many believe you should never give up," says Dr. Erel. And often these physicians choose to continue treating their dying patients as if they will recover.

This leads to additional problems related to the management of symptoms in the hospice patient. "Pain control is very important in hospice," says Dr. Erel, "and there have been some great new discoveries regarding the use of narcotics, especially morphine, in pain control. New studies show that almost 100% of the time we can achieve pain control and still have an alert patient."

However, many physicians avoid prescribing narcotics for fear their patients will become permanently addicted — a mute point for the patient who has only weeks or months to live, she adds.

Also, "physicians resist the use of narcotics because of previous education and their unawareness of the newer findings," says Dr. Erel. "The traditional training of physicians in pharmacology says to avoid the use of narcotics because most of the literature is based on studies with post-operative patients. However, cancer patients respond very differently."

Among the most common myths associated with the use of these drugs, she says, is that "if you give narcotics, you won't be able to increase the dosage to control pain later. That's not true — you can increase the dose extensively and continue to control pain," she says. Another myth is that "the patient will experience a lot of vomiting or respiratory depression. If the dose is increased only in response to the amount of pain, this is rarely the case."

Dr. Hall has equally strong feelings about hospice's emphasis on pain control and about physicians' hesitancy to adhere to it. Most problems, he says, revolve around the frequency of use and the amount of the dosage. "A lot of physicians are afraid of using strong medication," he says. "They're afraid the patient will be overly sedated. They are not used to using morphine and other strong drugs to relieve pain. Certainly there can be side effects — there's no getting around that — but you have to weigh these with the good they are doing the patient."

The major goal of hospice, Dr. Hall reiterates, is to make the patient *feel* better — not to make him or her better. "It all boils down to your approach to quality of life. Do you want to spend your last days with tubes in your nose and stomach and in each arm and with people pounding on your chest? Or do you want to die quietly and gracefully, free of pain?"

Perhaps the greatest consideration in deciding whether or not to refer a patient to hospice is the patient's attitude, desires and philosophy on the subject. Hospice is not for every terminal patient, Dr. Wheeler warns. It can even be harmful to the patient not able to accept death is near.

"Some patients have very strong denial mechanisms — they are not ready for hospice now and they never will be," he says. "It's important that you not break that denial, because it could destroy the person."

The major goal of hospice is to make the patient feel better — not to make him or her better.

Likewise, some family members may not be up to the hospice alternative, points out William D. Smucker, MD, one of three volunteer medical directors at Hospice of Medina County, Inc. "Today we have several generations who have never seen a family member die at home," he says. "Hospice may not be right for those who feel they can't handle it."

A death at home is a particularly stressful situation when there are unresolved family conflicts. Yet for the family which chooses the hospice alternative, it can present an opportunity to resolve past differences and put old squabbles to rest. With the help of social workers, clergy and other hospice workers, "all of these petty jealousies and past differences can be aired and conflicts can be resolved before the patient dies," says Dr. Smucker. "If there is a silver lining to a terminal illness — and I believe there are several — it is this last opportunity to bring things out in the open and to bring the family together again. This just isn't possible when a patient dies suddenly."

One of the smallest hospice programs in the state, Medina County's hospice is run largely by volunteers on a shoestring budget of $22,000 a year. While there is no dedicated inpatient unit, the local hospital accommodates hospice patients admitted for respite care by rolling out the extra hospital bed and bringing in a fold-out couch so family members can sit and chat or spend the night if they choose. Extra blankets, food and drink frequently are brought in, including ice cream and snacks. Some families stay late into the night joking and talking with patients.

The scene contrasts sharply with the unit across the hall, where other terminal oncology patients are receiving traditional care on IVs and respirators — the preferred treatment for some patients and their families.

However, hospice offers dying patients and their families who have successfully come to terms with an imminent death a choice, says Dr. Smucker, at a time when choices seem few and far between. "The terminally ill patient may feel completely out of control," he says, "because there is nothing that can be done about the illness. But at least the patient can choose the place and conditions of death — which may restore some feeling of control."

Hospices also give physicians a chance to say something more than "I'm sorry we can't help you," says Schmoll. "Physicians can still do a lot for a dying patient — even when medical skills aren't doing a lot of good."

Most hospices prefer that the primary care physician remain in charge of the day-to-day care of the hospice patient. The personal physician generally "knows the family better than anyone," says Dr. Smucker. Thus, he or she can be an invaluable member of a hospice team. If the physician feels unfamiliar or uncomfortable in that role, however, responsibilities for the patient can be shared with the medical director or deferred to the hospice.

Yet hospice is not out to take patients away from doctors, Dr. Erel insists. "We prefer that the referring physician continue to be involved in the patient's care," she says, although that care often steps beyond the bounds of traditional medical care. One example is that physicians are asked to make house calls — not just to check up on the patient but also to consult with family members and let them know they haven't been abandoned.

What's more, she adds, hospice can help physicians as well as patients and families get through this traumatic ordeal. Often the hardest step for the physician is getting up the courage to tell the patient he or she is going to die.

"If the physician hasn't adequately prepared the patient to know the prognosis, we encourage him or her to consult with hospice about how to go about it," she says. "Hospice is here to educate and comfort physicians who have dying patients — not to compete with them."

Finally, physicians who refer their patients to hospice needn't feel they have given up hope. "What you are offering through hospice," says Dr. Smucker, "is an opportunity for the patient to spend those last days at home with the family — a chance to focus on those things that have been most important in the patient's life, and to leave life knowing that important issues have been resolved." In this respect, he adds, physicians can feel comfortable knowing they did everything possible. **OSMA**

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The Long-Term Terminally Ill. Who will pay their bills?

An Overview

By Karen S. Edwards

Chances are, the terminally ill patient who has reached the last six months of life has, somewhere along the line, been involved with long-term care. It's a safe assumption, as new medical knowledge and sophisticated technology continue to prolong the life of individuals whose existence, even decades earlier, would be substantially shorter. But just as long-term care has become more common, it has also become more expensive — and who pays for these victims of catastrophic illnesses has become one of the most perplexing problems of the eighties.

Where the problems lie

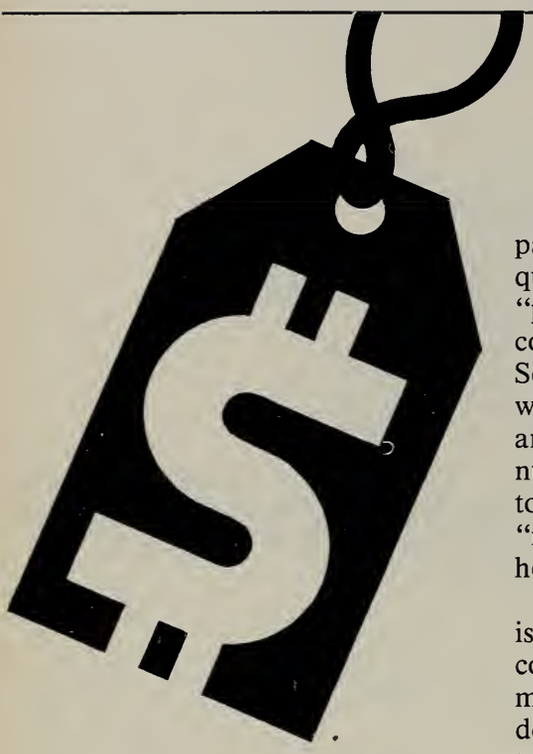
Traditionally, the long-term care patient has turned to Medicare and Medicaid to pay bills, and currently, these systems are still picking up the bulk of the tab. In nursing homes, for example, (where a patient who is 75 years of age or older can spend down to a level of impoverishment in just 13 weeks), Medicaid pays 90 percent of the bill, while Medicare continues to pick up the majority of a patient's hospital costs.

But nothing is forever. Experts are already predicting that the federal trust fund that pays for Medicare's hospital insurance will be bankrupt by the year 1996 — and proof is close at hand.

Fortney H. Stark, chairman of the House Ways and Means Health Subcommittee in Washington, says, in a recent article in *Medical World News,* that approximately 280,000 Americans run out of their "part A" Medicare benefit each year. "Part A" is the section of Medicare that covers hospital costs. This section currently pays *all* covered hospital bills for the first 60 days of hospitalization (after a $492 deductible). The next 30 days of hospitalization, patients are billed at a rate of $123 per day, and after 90 days, the patient must use a 60-day lifetime allotment of reserve days, paying up to $246 for each of these 60 days. Once the reserve allotment is exhausted, Medicare payments cease . . . and, as Congressman Stark points out, those allotments are running out too soon — for thousands of people who still need them.

To ease this situation (and ultimately to lower costs), the federal government responded with DRGs — the prospective payment system which was put into place in Medicare in 1984. Whether or not DRGs have been effective depends, to a large extent, on whom you talk to — but few will argue that they have created problems for the chronically and long-term ill in our society by setting off a troublesome chain reaction.

According to a recent study which examined the effect of federal policy changes since 1981 — conducted by the University of California, San Francisco, and published in the *AMNews* — DRGs often mean that elderly



Paying the bills . . . *continued*

patients are returning "sicker and quicker" to communities which are "poorly prepared to provide the comprehensive services they need." So, a chain reaction is initiated, in which newly discharged patients are displacing the chronically ill in nursing homes and bumping *them* to what the study terms the "newest institution" — their own homes.

Once there, however, the patient is hard-pressed to find enough community health care services to meet his or her needs. Increased demand for these services is partly to blame, but competition is enlarging the problem, as nonprofit companies now find themselves having to square-off against the for-profit agencies — forced to use the same private-sector methods to get ahead: i.e., winning price competitions, promoting quick turnover of clientele and eliminating unprofitable services.

"To keep costs down," says Carroll Estes, one of the researchers involved in the San Francisco study, "an agency not only needs clients for whom it can obtain reimbursement, but also needs clients who will not require heavy care or an inordinate amount of resources."

As a result, battles rage over Medicare patients, but few agencies — for *or* nonprofit — are interested in the medicaid patient, who, in many cases, turns out to be the patient with a long-term illness.

So, usually, it is a family member who must step in and assume the responsibility of care giving. Although at first glance, this solution may seem to be a reasonably priced alternative, upon second glance, it is not. Care givers, statisticians are learning, are often in poor health themselves and unable to withstand the physical and emotional strains such care giving demands. This is especially true in the case of the elderly, where recent figures from the Department of Health and Human Services reveal that 1.2 million sick, elderly people depend on 2.2 million *other* seniors for their care — usually spouses or close friends. These care givers, however, have become increasingly prone to strokes and heart attacks, resulting in acute hospitalization for the care giver, and possible re-hospitalization for the terminally ill patient.

Which brings us back to the leading question — who will pay for their care? If Medicare and Medicaid are not the answers, what about private insurance?

If the patient's long-term terminal illness is linked to AIDS or an AIDS-related complex (ARC), the answer is quite likely "no." A report in a recent issue of *AMNews* reports that the estimated one to two million Americans exposed to the AIDS virus will find it increasingly difficult to purchase insurance, and the more than 9,000 presently diagnosed AIDS patients and 150,000 ARC patients will find buying insurance to be virtually impossible. Even those who have insurance *now* may find it difficult to collect.

However, long-term care insurance (for other illnesses) *is* one of *several* financing options currently under investigation — any one of which may offer the long-term terminally ill and their

As the "affluent elderly" population grows, the individual is beginning to shape up as a viable answer to who pays the bill?

families increased hope of paying future health-care bills.

Some suggested solutions

Before looking specifically at long-term care insurance — probably the most viable financial option being explored today — let's take a look at *all* the options which are under consideration at this time — by private, public and government sectors. These are:

1. *Individual responsibility*

Under this option, patients themselves would be responsible for picking up a large portion of their long-term care bill. This is already being done, to a great extent, in nursing homes, where an estimated 42 percent of total nursing home expenditures is being paid for through private payments from nursing home residents or their families.

Of course, the ability of individuals to pay privately is limited by their level of personal resources. In 1985, about 28 percent of all elderly households (the section of the population most in need of long-term care) had incomes of less than $5,000. Nearly 60 percent had income levels of less than $10,000.

However, a recent report in *Marketing News* claims that an estimated seven to nine percent of the 26 million Americans aged 65 and older have annual incomes of $20,000 or more . . . and this population is on the rise.

"The affluent elderly already have put their children through school, and more than 76 percent own their own homes. With major expenditures out of the way, a $20,000 income translates into a tremendous amount of discretionary buying power," the article states.

And health *is* a key issue in the minds of the 65-and-older population, the article continues. "Our data indicates . . . there is a strong demand for health services and facilities in case the need arises."

So, the individual is beginning to shape up as a viable answer to the question, "Who pays the bills?" As the "affluent elderly" population continues to grow, and their need for long-term care services expands, the private patient may well offer one of the best opportunities for getting those long-term care bills paid.

2. *Filial responsibility*

Gone are the days when grandmother or grandfather moved in with a son or daughter to spend their last few years of life.

As already stated, the majority of care givers today are seniors themselves, and since the early 1970s, senior citizens have been *encouraged* to volunteer their time and energy in programs which offer respite care services. As a result, seniors are now providing relief care to other seniors who wish for a break from their 24-hour care giving responsibilities. To make this volunteering even more appealing, many states have begun to institute "volunteer service credit programs," in which a senior may receive "credits" for providing respite care. Then, when the volunteer senior becomes disabled, his or her earned "credits" may be "cashed in" for so many hours of care.

Sometimes, however, the care giver is a young person, and, if that's the case, chances are the care giver is a female — probably a daughter or daughter-in-law of the patient. Many of these women have given up full or part-time jobs to take care of mom or dad (or grandmom or granddad) — but such filial care givers are rare, and will become even more uncommon, says Philip R. Lee, MD, a principal investigator in the San Francisco study.

"Families won't be able to assume this burden in the future, because without two incomes, they won't be able to survive as an economic unit, or because the family is headed by a single parent," he says in an issue of *AMNews*.

And, frankly, the patient's family has little incentive to care for its ailing member — but this point will be more thoroughly discussed under the heading "government's responsibility." Presently, little is being done at either the state or national level to mandate filial or family responsibility — but discussion on this issue is far from over, and children may yet find themselves financially responsible for a relative's illness.

3. *The responsibility of the private marketplace*

The private sector is presently investigating several different ways to alleviate the expense of long-term care. One of its most recent approaches is the establishment of four experimental national social health maintenance organizations (S/HMO) — organized by the Health Care Financing Administration (in conjunction with Massachusetts' Brandeis University).

Under the S/HMO concept,



Paying the bills . . . *continued*

individuals voluntarily enroll in plans that provide a specific set of services for a guaranteed price per person — paid upon enrollment. While the HMO provides a range of acute, preventive and some long-term care services, the S/HMO provides enrollees with chronic care benefits as well.

What futurists are hoping will result from the HMO and S/HMO concept is the evolution of a "gatekeeper" — an entity which will provide a bridge between formal, institutional care and a more informal community care network. It may work, as HMO and S/HMOs eliminate unnecessary use of nursing homes and other institutions — while reducing the fragmentation of services out in the community. But many believe that their current emphasis on risk avoidance through selective enrollment will leave a significant number of elderly without the protection they need.

Another approach which the private sector — especially hospitals — have decided to use in their battle to alleviate costs is the development of continuing care facilities.

Suddenly, such facilities — alias "life care communities," or "retirement communities" — are springing up all over the country, offering a combination residential and medical-social environment which includes security and numerous social benefits as well.

In a sense, these communities can be construed as long-term care insurance policies — without the risks associated with a fixed-price indemnity contract. And hospitals are beginning to look at these facilities as a new way to "vertically integrate" (health care's latest buzzword) patients into their system.

"Hospitals are moving toward providing a continuum of care through a three-tiered institutional structure," says DeWayne Oberlander, associate vice president of Pennsylvania Hospital, in a recent issue of *Hospitals* magazine. Such a structure will include acute care, skilled-nursing or intermediate care, and such independent-living programs as day-care centers, home health care, respite care and life care communities.

But life care communities do not come cheap — for either the patient or the financing institution.

"I can understand clearly why a hospital or medical center would not get involved in life care communities," says Carl Eisdorfer, MD, professor and chairman of the department of psychiatry at the University of Miami, in *Hospitals* magazine. "They involve very complicated financing and require an enormous amount of equity."

The typical long-term care facility usually requires of the patient an initial refundable (or non-refundable) deposit fee, and a variable monthly service charge.

Newer communities, termed "congregate housing with services," however, are being developed which require *no* entry fee. Instead, they offer a lease/rent arrangement, alleviating the pressure on the provider to provide health care services for life. Currently, Sears and a development company known as Activelife Retirement Communities

Another approach being contemplated is a "health care savings account," combining employer funding and a 60 percent federal income tax credit for contributions.

are actively pursuing this new health-care option. How well it does, and how fast it grows will depend, to a large extent, on just how affluent seniors and their families really are. Even without the risks, such facilities are expensive insurance policies, and, as such, are questionable, though perhaps necessary options for long-term care.

4. *The government's responsibility*

In response to the question, "Who will pay for long-term care?" the government is turning to a series of tax incentives, in hopes that these incentives will stimulate individuals to finance their own care.

Certainly, the government's move to extend IRA eligibility is one method that is being used to encourage private financing of future long-term care needs. And it appears to be working. In 1982, when IRA eligibility was first extended, 11 million taxpayers claimed IRA deductions on their tax returns. The next year, that number had increased to 13 million, and, in 1984, the number increased another 20 percent to 15.4 million.

Admittedly, IRAs are not going to alleviate costs for *today's* chronic patient — but they will help *tomorrow's* long-term care patient *if* the tax code can be revised to enable an individual to continue contributing (and accumulating funds) beyond age 70½. Presently, the government is mandating no further deduction for contributions to IRAs after age 70½, and, further, it requires an individual to distribute these funds at this age — whether they're needed or not. But current nursing home statistics show that the average admission age of nursing home residents is between 75 and 80 years, and that figure is likely to increase in the future. That means that individuals could have at least another five years to accumulate adequate principal in their IRA account — at least enough to pay for their long-term care, if only the government would respond.

Yet another approach being contemplated is a "health care savings account," which would combine both employer funding and a 60 percent federal income tax credit for contributions. (There is no secret that this legislation is intended to replace Medicare coverage for all hospital costs — except the most catastrophic expenditures.)

What these "health-care IRAs" would do is provide individuals with tax credits for purchasing long-term care insurance. In addition, any future fund accumulations spent on medical expenses would be excluded.

The health-care IRA is not meant to be a replacement for a general IRA. However, many economists feel it is an attractive supplement — and one which offers greater income and investment flexibility to individuals.

A third financing option the government is considering is allowing voluntary copayments to a provider — in addition to what current public assistance programs allow. At present, the law prohibits providers from seeking any additional payment from individuals or families that would be beyond the Medicaid reimbursement for covered services. By allowing such voluntary payments — and rewarding the individuals who pay with tax credits — the pressure on public programs to maintain adequate services would not only be eased, but families, encouraged to assist in the financial support of institutionalized relatives, would create an additional revenue source for providers, allowing them to enhance the quality of care.

Finally, the government may eventually look into the possibility of eliminating some present financial tax laws which serve as disincentives for providing informal care.

In the publication *Business and Health,* Tom Jazwiecki, director of the office of reimbursement and financing at the American Health Care Association in Washington, explains:

"Internal Revenue Code (IRC) section 151 allows a personal exemption for each dependent whose gross income for the calendar year is less than $1,040 for 1985. A disabled individual having a gross income of just $1,040 (less than $20 per week), may not be claimed as a personal exemption, even though the family may be the main contributor to the individual's support. Furthermore, IRC section 152 defines the term dependent as one who receives more than half of his or her support from taxpayer contributions. This definition ignores the reality of situations where the taxpayer contributes significantly to the welfare of an aged or disabled person, but falls short of the 50 percent monetary requirement."



Paying the bills . . . *continued*

Another example of a disincentive, he continues, is the law involving dependent care credit. As it stands, the law does not make it conducive to caring for the aged or disabled — or even utilizing adult day care programs. Again, Jazwiecki explains:

"For married taxpayers, for example, the qualifying expenses are limited to the earned income of the spouse with the lesser income. Generally speaking, no credit is allowed if one spouse does not work. Second, taxpayers must contribute more than one-half the support for the individual to qualify as a dependent under IRC 152. Third, linking the credit to the more than 50 percent support requirement under IRC 152 dissuades multiple cooperative arrangements among family members, each of whom may be capable and willing to care for the individual, but only for a portion of the year."

Once these disincentives are eliminated, chances are that more individuals will be willing to provide the informal level of care giving which may prove to be the backbone of financing long-term care options.

5. *The private insurance option*

It is private long-term care insurance, however, that looks to be the most viable — and affordable — financing option for long-term care.

Long-term care insurance is a relatively new product in the health care marketplace, and is different from the Medicare supplemental insurance that is currently being hyped on television by big-name (but generally older) entertainers.

What long-term care insurance does is permit coverage which *exceeds* the limited extended care benefits of Medicare by providing purchasing support for services lasting longer than six months (usually three to five years). And this insurance places no restrictions on an individual's rehabilitative goals or recuperative potential. In other words, long-term care insurance *can* be used by both the chronically and terminally ill.

But will it?

According to Jazwiecki, the insurance industry "by its very nature" is conservative, and certain federal and state initiatives may be necessary to accelerate product development — and to prompt consumer acceptance.

"One positive approach would be the creation of state and federal tax incentives aimed towards the creation of long-term care insurance. Such incentives could include major tax credits to individuals for the purchase of long-term care insurance; an accelerated write-off by insurance companies of research and development expenses associated with long-term care insurance products; and special taxation incentives for premium advances, premium income and loss reserves."

With or without these incentives, however, there already appears to be a ground swell of interest in state legislatures across the country. For instance, Georgia, Texas and New Mexico are all states that, over the last two years, have enacted legislation to study the feasibility of private long-term care insurance. Connecticut, Illinois, Maryland, North Carolina and North Dakota have recently introduced such legislation, and

Chances are, we can look forward to seeing more insurance products, more tax incentives, retirement communities, S/HMOs, and patients digging into pocketbooks.

Colorado and Kentucky have expanded existing health care studies to explore long-term care insurance. Other states have followed (though Ohio has yet to take any actions in the legislative area).

Yet, in the wake of increasing legislative interest, the National Association of Insurance Commissioners *has* convened a special advisory committee on private long-term care insurance, and will be studying the option over the next year.

The products that have already emerged in long-term care insurance include the following:

- a limited benefit indemnity protection for nursing home care.
- a broader plan which covers both nursing home and home health care.
- reinsurance of the health care component of a full service retirement center and
- a single premium guaranteed income supplement annuity that would begin annuity payments at some future date.

Prices for these policies vary considerably — by age of the insured, coverage factors and payment liability.

In his article in *Business and Health,* Jazwiecki gives the following example:

"Annual premiums for an individual aged 60 to 64 ranged from $250 to $500, increasing with age, so that by age 70 to 74, the costs become $700 to $1300."

But while these premiums *are* costly, they do not even begin to approach the monthly cost of nursing home care which can range from $1000 to $1500.

And, at least, they are there — whereas just a few years ago such insurance policies simply didn't exist.

Chances are, we can look forward to seeing more insurance products — just as we can look forward to seeing more tax incentives, retirement communities, S/HMOs — and patients, as well as their families, digging into their pocketbooks to finance their long-term care.

Which may be just as well, for as America continues to grow older, and the marvels of modern medicine manage to keep individuals alive longer, it is going to take the combined efforts of everyone — individuals, family, government, as well as both the public and private sectors to resolve the question of who will pay for this nation's long-term ill. — OSMA

Karen S. Edwards is Executive Editor of the **Journal.**

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Second Opinion

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of the vehicle to impoundment, removal of the vehicle license plates and their transmission to the Bureau of Motor Vehicles, and transport of the driver to a police station for identification and fingerprinting. OSMA

William H. Havener, MD, is an ophthalmologist practicing in Columbus.

How One Ohio Hospital Resolved the DNR Question

Cardiopulmonary Resuscitation Guidelines at Cleveland Metropolitan General and Highland View Hospitals

By Mary Mahowald, Ph.D., Daniel Schubert, MD, Ph.D., I. Bruce Gordon, MD
Case Western Reserve University, School of Medicine

"If Hippocrates were alive," Editor Karen Edwards wrote in the June 1985 issue of this *Journal,* "he'd probably be drafting a whole new code."

In a recently litigated case regarding a physician's decision not to resuscitate an 87-year-old woman, New York Hospital was ordered to develop written guidelines regarding resuscitation of patients. As moral and legal quandaries increase in the practice of medicine, the need for "Hippocrates' new code" is increasingly evident. Nursing homes and hospitals have responded to this need by developing policies which may guide practitioners in addressing complex ethical issues that confront us because of advances in biomedical technology. During the last year, Cuyahoga County Hospitals has developed a policy that we believe will assist health caregivers, families and patients in addressing these issues. In order to facilitate the formation of such policy in other institutions, we wish here to share the fruits of our efforts. What follows, therefore, is a description of the process through which we undertook the development of the policy, and the text of the policy which resulted.

The Process

Initially, the leadership of the hospital convened an interdisciplinary committee to explore ways through which ethical



Cleveland Metropolitan General Hospital in Cleveland.

questions at the hospital might best be addressed.

It was our plan that the committee organized should have full representation from all disciplines that would be involved in planning and carrying out DNR policies at the hospital. Representation was sought and accepted eagerly from the Department of Social Service, Nursing, and the Chaplaincy, in addition to medical disciplines. The latter group included representatives from all departments who were likely to deal with this issue, and included members representing the several longitudinal components of the institution (acute care, rehabilitation and skilled nursing facility).

Hospital Administration and legal services were not included but were involved as consultants.

This group chose to direct its energies to development of hospital policy regarding the withdrawal or foregoing of life-saving treatment. They first read a variety of articles on the subject, including selections from the report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research *(Decisions to Forego Life-Sustaining Treatment),* and sample guidelines from other institutions (e.g., those included in Section III of *Institutional Ethics Committees and Health Care Decision Making,* edited by Ronald Cranford, MD and A. Edward Doudera, JD). At biweekly meetings we decided that our overall approach should include a preliminary statement of relevant ethical principles, definitions and distinctions, followed by elaboration of the procedures to be followed in order to observe those principles in specific cases. In general, we fashioned our final document in a democratic manner,

The DNR Question . . . *continued*

suffering the infelicities which that process sometimes engenders. We believe that other institutions might develop their own document in a similar manner, possibly using our own as a suggestive outline.

Cardiopulmonary Resuscitation Guidelines

Cleveland Metropolitan General/Highland View Hospital

Preamble

The policy of Cuyahoga County Hospital continues to be that of providing the highest quality medical care to its patients and their families with the objective of sustaining life and practicing in conformity with the highest ethical and medical standards.

Accordingly any patient who suffers cardiopulmonary arrest will ordinarily be resuscitated. There are times, however, when the question of whether such cardiopulmonary resuscitation should be undertaken is legitimately raised. The following principles and procedures are offered as guidelines for addressing these difficult cases.

Principles

From an ethical standpoint, the informed, autonomous decision of a competent patient has priority in determining if resuscitation shall not be initiated.

If the patient is incompetent or questionably competent, or if it is impossible to ascertain the patient's wishes, the obligation to act in the patient's best interest has priority over other persons' wishes.

To the extent that the wishes of an incompetent patient have been previously indicated, for example, through a living will, or through the family's account of the patient's disposition, these should be *considered.* To the extent that ambiguity remains about the patient's wishes, and about what constitutes the best interests of the patient, a presumption in favor of resuscitation is appropriate.

Definitions

Cardiopulmonary Resuscitation (CPR) — The emergency procedure which artificially supports the circulation and respiration of a victim of cardiac or respiratory arrest.

No CPR Order — When a **No CPR Order** is written, the patient will receive all medically appropriate therapy but cardiopulmonary resuscitation will not be initiated.

Competent Patient — A patient shall be considered to be competent if the patient is:

(1) an adult, or an emancipated minor*; and
(2) conscious; and
(3) able to understand the nature and severity of the illness involved; and
(4) able to understand the possible consequences of alternatives to the proposed treatment; and
(5) able to make informed choices concerning the course of treatment.

*minor who is married or unmarried but self-supporting, living away from home and not subject to parental control or support.

Incompetent Patient — A patient shall be considered to be incompetent if the patient is:

(1) a minor (unless emancipated); or
(2) unconscious; or
(3) unable to understand the nature or severity of the illness involved; or
(4) unable to understand the possible consequences of, or the alternatives to, the proposed treatment; or
(5) unable to make informed and deliberate choices concerning the course of treatment; or
(6) has been declared legally incompetent by a court.

Procedures

1. The question of a **No CPR Order** may be raised by the patient, family, or staff.
2. Regardless of who initiates the discussion, the patient's attending physician or senior level resident must determine if a **No CPR Order** is medically appropriate, based on the patient's underlying terminal illness or irreversible medical condition.
3. If the attending physician and/or senior level resident determine that a **No CPR Order** is medically appropriate, the physician must discuss the matter with the patient, explaining the basis for, and the consequences of, the order.
4. If the patient is incompetent this discussion must be held also with the patient's family or legal guardian. The views of the family members or the legal guardian should be strongly considered, but the patient's previously expressed views and his/her best interests are also to be considered. Parental consent must be noted in the case of a minor.
5. All such discussion must be noted in the progress notes on the patient's medical record. The notation of such discussions shall include at least the following information: **persons present; the condition of the patient; information conveyed by physician; and the**

wishes of the competent patient, or the expressed views of the incompetent patient, his family or legal guardian, if one exists. The order must then be written on the order sheet.

Oral orders may *not* be implemented.

6. The attending physician or senior level resident shall discuss the **No CPR Order** and its meaning with all appropriate members of the hospital staff.
7. All **No CPR Orders** shall be reviewed regularly.

   Since the various **units** in the Cuyahoga County Hospital System have different requirements consistent with their patient's needs, the following review process will be established:

   Metropolitan General Hospital — **No CPR Orders should** be reviewed and rewritten on the order sheet at least every 72 hours.

   Highland View Hospital — **No CPR Orders should** be reviewed and rewritten on the order sheet at least every 2 weeks.

   Sunny Acres Skilled Nursing Facility — **No CPR Orders should** be reviewed and rewritten on the order sheet at least every month.

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In choosing to focus on cardiopulmonary resuscitation policy, we consciously ignored ethical dilemmas concerning other modes of life-saving treatment. Having completed that effort, we are now addressing those other modes, attempting to establish clear guidelines consistent with the same ethical questions, including the use of a hospital ethics review committee for specific cases.

We present this policy as a stimulus to hospitals where guidelines may yet need to be developed. Incorporation of useful elements of our approach in documents of other institutions would facilitate a broader understanding and more consistent practice on the part of physicians, other health care workers, patients and families. We hope that our sharing this information may also assist public policy makers, who address complicated questions of medical ethics in the laws they enact for our state. Such laws, we believe, deserve thoughtful input both from practitioners and from the public. **OSMA**

The authors are from Case Western Reserve University School of Medicine in Cleveland.

References

Cranford, R.E. and Doudera, A.D. (eds.): *Institutional Ethics Committees and Health Care Decision Making,* Ann Arbor Health Administration Press, 1984. This is an up-to-date collection of articles about the origin, roles, legal and ethical aspects of hospital ethics committees, alternative approaches, and sample policies and guidelines not only for committees but also for "Do not resuscitate" orders and "living wills."

Doudera, A.E., Peters, J.D. (eds.): *Legal and Ethical Aspects of Treating Critically Ill and Terminally Ill Patients,* AUPHA Press, Ann Arbor, Michigan, 1982. This is a collection edited by two lawyers, focusing on critical care issues but not on committees. It includes useful appendices: guidelines from different institutions, comparison of right to die laws, crimes which may be committed against terminally ill patients.

Kliegman, R.M., Mahowald, M.D., Youngner, S.J. "In Our Best Interest: Experience and Workings of an Ethics Review Committee," *Journal of Pediatrics,* forthcoming. This article provides guidelines, describes procedures and illustrative cases of a pediatric ethics review committee at Rainbow Babies and Childrens Hospital in Cleveland.

McCormick, Richard. "Ethics Committees: Promise or Peril," *Law, Medicine and Health Care,* Sept. 1984, pp. 150-155. A brief and balanced account with "four basic non-threatening recommendations" for a well-functioning committee.

Levine, Carol. "Questions and Answers about Hospital Ethics Committees," *Hastings Center Report* 14, June 1984, pp. 9-12. Another balanced account, addressing most of the questions typically raised by those considering committees.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment,* U.S. Government Printing Office, March 1983. This entire book is an excellent resource for ethical issues relevant to the critically ill. The content is clearly and adequately developed with helpful notes and references. Chapter 7 deals especially with resuscitation decisions for hospitalized patients. The President's Commission here proposed the establishment of hospital ethics review committees as a preferable mechanism to government intervention.

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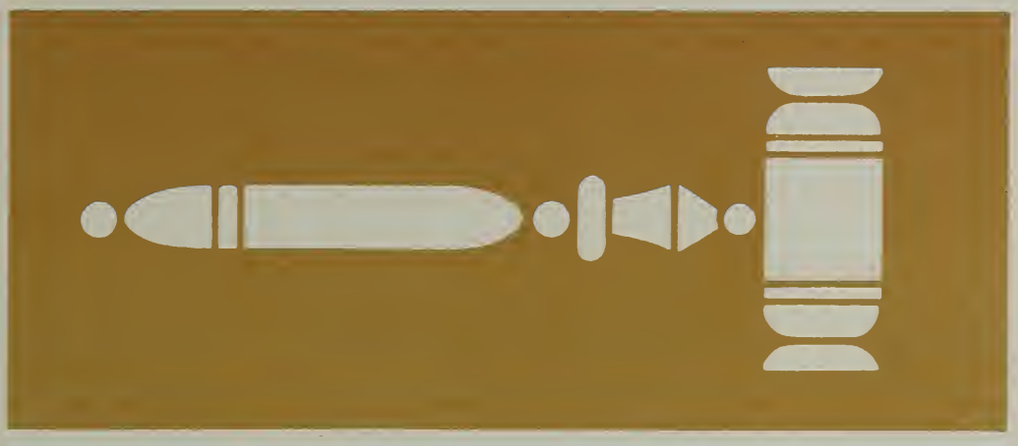
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Legal Approval of Life Support Decisions

By Judge Lawrence Grey
Fourth District Court of Appeals

As a judge I was pleased to read of the recent report[1] of the Council on Ethical and Judicial Affairs of the AMA at the meeting in New Orleans. The council decided that discontinuing life-prolonging medical treatment, including food and water, from irreversibly ill patients was not unethical. This decision was a step in the right direction in resolving the thorny medico-legal problem arising out of the treatment of terminally ill patients. The problem arises, I believe, from a failure of the legal system to recognize what is essentially a medical question and what is a legal question.

Before I go any further, a caveat is in order. I am editorializing — telling you what I think the law should be, and what I expect it to be. Lest there be any misapprehension, I should mention the leading case in Ohio on the termination of life support is *LEACH vs. SHAPIRO.*[2] In *Leach,* an elderly woman suffered cardio-pulmonary arrest, was resuscitated and placed on life support with a respirator, nasogastric tube and catheter.

Her condition was described as comatose and chronic vegetative. After four months the family asked that life support be terminated, but the doctor and the hospital refused to do so without a court order. While the *Leach* case involved other issues,[3] on the issue of termination of life support the 9th District Court of Appeals in Akron held:

> In Ohio, at this time, the court system provides the only mechanism which can protect the interest of the doctor, the hospital, the patient, the family and the state, which can objectively weigh the competing interests in an emotionally charged situation, and which can insulate the participants from civil and criminal liability. Until such time as the legislature provides some more efficient means of protecting the rights of patients in Mrs. Leach's condition, we join those courts that require judicial authority for the termination of life-prolonging treatment of an incompetent patient.[4]

This decision by the 9th District is the only reported case in Ohio on this issue. There is no Ohio Supreme Court decision as yet. *Leach* is not binding on any other appellate court, but it would be a prudent practice for a doctor or

Legal Approval . . . *continued*

hospital to consult with an attorney about obtaining a court order before terminating life support.

Now having told you what the rule is, I want to add that I believe the rule in *Leach* is not a good rule, and probably will be discarded. The *Leach* case blurs the distinction between medical decisions and legal decisions, and as a result complicates the decision making process for both professions.

In the good old days the distinction between what was medical and what was legal was, like death itself, quite precise. Death was the end of the medical process; death was the start of the legal process. Medicine decided when a person was dead. The law then decided the effect of the death, i.e. who inherited property, who might be convicted of murder, etc. With the coming of the various life-prolonging medical advances, the legal decisions became less sure.

There is a need for certainty in the law, and as Ben Franklin assured us, nothing is as sure as death. The sureness of death, its inevitability, made it a useful legal tool. It answered a lot of difficult questions. When should a woman be allowed to have a second husband? When is the office of king vacant? When does a farmer's son have the right to call the farm his own? One could propose several reasonable standards for answering any of these questions: age, competence, a term of years. But any or all of them are likely to lead to family, social or political squabbles. Death is an easy answer: when the husband is dead, or the king is dead, or the farmer is dead. Death is a nice absolute!

Doctors often wonder: "Why do we need a legal definition at all? Death was, and basically still is, a medical diagnosis." I would answer by saying that death affects legal relationships in ways a physician may not realize. Double indemnity life insurance is a good example. Life insurance policies often provide payment of double the full policy amount if the insured dies accidentally. These double indemnity clauses usually provide that the added benefits are to be paid only if the insured dies within 90 or 120 days of the date of the accident.

It's easy to see how life support can muddy the legal waters. Suppose a young man, an accident victim, lies in an irreversible coma and meets all standards for brain death. Suppose he has a wife and three children. If life support is terminated and he dies now, she gets $50,000. If he is kept on life support past the 90th day, she gets $25,000. How is she to choose? The Pennsylvania Supreme Court[5] ruled this was too terrible a choice to have to make, and barred the 90 day time limit. In Ohio, the 90 day time limit for people on life support was upheld.[6] Thus as a physician practicing in Ohio, your decision on terminating life support may affect your patient's life insurance contract whether you intend it to or not.

In a similar manner, legal decisions are going to affect the practice of medicine. Take organ transplants, for example. The various human organs and tissues are ranked in terms of complexity on the phylogenic scale. As a general rule, the higher on the scale or the more complex the tissue, the shorter the period of time the tissue can be restored to normal function after a period of anoxia. Thus a legal definition of death will be an arbitrary line drawn across the phylogenic scale. Those organs best able to survive anoxia will be more transplantable; and those least able will be less transplantable. Whether intended or not, the law will affect medical practice. Contracts and human physiology being as they are, doctors and lawyers cannot avoid some intrusion into the others' field.

What can be avoided are situations where the legal system's intrusion into the practice of medicine produces no useful results. Discontinuing life support is often one of those situations, and that's why I believe the council's standards are a step in the right direction.

The standards re-emphasize the need for physicians to do those things ordinarily expected of a doctor. He is to sustain life and relieve suffering. He is to keep his patient informed, and to follow the wishes of his competent patient, or to consult with the family or legal representative of an incompetent patient.

The standards allow for one significant change. They permit a physician who recognizes the limits of medical treatment to candidly advise his patient and the family of those limits. For the competent patient who can make his own choice, it is a difficult personal decision. With the incompetent patient someone else must choose, and this presents a serious moral

question for the decision maker. The committee standards recognize that the decision to discontinue life support is as morally correct, is as much in the patient's best interest, as the decision to continue life support.

The current status of the law requiring court approval for termination of life support is, at best, futile. It serves little purpose, provides little benefit, and creates a judicial controversy even where there is none.

Terminating life support creates a legal issue, but initiating it does not. This seems an anomalous situation. Most hospitals have a protocol for entering a DO NOT RESUSCITATE or no code order on the patient's chart. No code orders are routinely done,[7] after consultation with a patient or family. No legal issue is created. I did a computer search and could find no cases[8] where judicial intervention was felt to be needed. Nonetheless, the criteria for discontinuing life support are quite similar to those for a no code order.

The rule in the *Leach* case violates a basic legal tenet — courts are to decide controversies. Where there is no controversy, there ought to be no case. When the doctor and the hospital believe discontinuation is the best procedure to follow, and when the competent patient or the incompetent patient's family is convinced that he would not want to be kept hanging between life and death by intrusive, and expensive, medical technology, what is the controversy for the court to decide? If such a case went to court, the treating physician would tell the judge the same thing he told the family about the patient's condition. The family would tell the judge the same thing they told the doctor about the patient's wishes. What other decision can the judge reach? If there is a difference in medical opinion, or disagreement within the family, then there is justiciable controversy. Only then should resort to the courts be required.

Requiring court approval for the discontinuation of life support implies that continuation is a morally and legally superior course of conduct. The council's standards establish that discontinuation of life support is an equally valid moral and ethical course. In spite of *Leach,* I believe the courts will come to recognize that idea. **OSMA**

Lawrence Grey, JD, contributes frequently to the Journal. *His last article, on reporting child abuse cases, appeared in the July 1985 issue of the* Journal.

References

1. Reported in *New York Times* March 17, 1986
2. 13 OApp 3d 393 (1984)
3. A court order was obtained, see *Leach-v-Akron Gen. Medical Center,* 68 O.Misc. 1 (1980). Later the Leach family sued Dr. Shapiro and the hospital for malpractice for failing to discontinue life support. At trial the jury returned a verdict for the doctor and the hospital.
4. At p. 396, citations omitted
5. *Burne-v-Franklin Life Ins. Co.,* 301 A2d 799 (1974)
6. *Rhodes-v-Equitable Life,* 54 0S2d 45 (1978)
7. Case Western Reserve: Get Cite
8. A computer word research of all U.S. cases using the phrases, "DO NOT RESUSCITATE, D.N.R. orders, No-Code, No-Code Orders, and Slow Code;" turned up no cases. I am not, however, expert in the use of computerized legal research and cannot flatly say there are no such cases.
9. *The Do Not Resuscitate Order in a Teaching Hospital;* Miles, et. al., Vol. 96 Ann. of Internal Medicine, Pg. 660 (1982); *Choices About Cardiopulmonary Resuscitation in the Hospital,* (1984), Bedall et. al., Vol. 310 No. 17, New England Journal of Medicine, pg. 1089.
10. In study at University Hospitals in Cleveland, reported in *Do Not Resuscitate Orders,* (1985, Younger, et. al., Vol. 253, No. 1 JAMA pg. 54, 71 patients were followed six months after a DNR was put on. Most had died in I.C.U. but nine had been discharged from the hospital. Of the nine, 6 had died within 6 months, 2 were still seriously ill, but one said he tried "to jog a mile a day."

Colleagues in the News

Four University of Cincinnati Medical Center faculty members have been elected to Ohio Academy of Family Physicians offices. **THOMAS TODD, MD,** associate clinical professor of family medicine, has been named president; **F. JAY ACH, MD,** associate clinical professor of family medicine, vice president; **KENNETH FREDERICK, MD,** professor of family medicine, delegate to the American Academy of Family Physicians; and **DONALD K. EBERSOLD, MD,** associate professor of family medicine, District I director.

WULF UTIAN, MD, of Mt. Sinai Hospital in Cleveland, has been appointed to a Special Study Section of the National Institutes of Health to review research projects on menopause.

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How Physicians Wrestle With the Questions of Death

By Deborah Athy

Physicians, because of the very makeup of their profession, come face-to-face with death more than other professionals. Not only do they assist in the initial life process, they must also assist in the finalities, the closing chapters.

This means, at times, after science has done all it can do, the physician must step back and accept his or her own limitations, as well as the inevitability of death.

Some physicians, such as family practitioners, may lose a patient only occasionally; but for those who work with the elderly or with cancer patients, death is a regularly expected occurrence.

Vicki Whitacre, MD, an emergency room physician at Bethesda Hospital in Zanesville, faces death every day. "People die on me," she says, matter-of-factly. "I go to work each day fully expecting that someone is going to try to die." No one else in any other profession does this, she points out.

Oncologist Rebecca Bechhold, MD, who works at the Bethesda Hospital in Cincinnati, also deals with death on a regular basis. "My situation is going to be different than that of a family practitioner's, where deaths probably occur very infrequently." Because of her specialty, "it's an issue I have to deal with with every patient," she says.

Breaking the News

Considering the fact, then, that not every patient can be saved, how *do* you tell someone that he or she is going to die? "Breaking the news" is something that most doctors have to do at some time or another in their careers — and some, like Drs. Whitacre and Bechhold, have to do quite frequently.

Although doctors may all have their own unique approaches for broaching the subject, many prescribe a healthy dose of honesty. But not long ago, the going trend was to shield the truth.

In the 1950s, "when my father was dying of cancer, the psychiatric theory at the time was that the concept of death would be too overwhelming to the patient, too traumatic . . . It was thought that it was better the patient *didn't* think about it," recalls James R. Hodge, MD, professor and chairman of the department of psychiatry at the Northeastern Ohio Universities College of Medicine in Akron.

"As a family, we were supposed to help him forget about it. And, unfortunately, that's what we did."

Since that time, things have changed — not only in the technology of medicine, but in the psychology of medicine as well.

Physicians wrestling with death . . . *continued*

"Today, I would discuss it (the illness) often with him, and I would give him progress reports on his condition from the medical point of view. I would encourage him to finish any uncompleted tasks and to get his affairs in order," Dr. Hodge says.

"I would make it a point to be open, honest and trustworthy. But, at the same time, I would try to give him some hope. Medical research is being done all the time . . . new treatments are always developing. I think this is the kind of thing we can legitimately say to our patients."

In addition, "I would assure the patient that he will be kept as comfortable as possible and that his dignity will be maintained at all possible costs," he says.

Dr. Bechhold also believes that honesty is the best approach a physician can take. "When I first see a patient, it may be clear that he or she has a limited survival. I try to make it clear that I can't cure them. You have to be honest, but diplomatic," she explains. "You don't cover things up, but you can be discreet about the diagnosis. Some doctors just say, 'You're going to be dead in six months.' "

Bechhold says this kind of no-hope, dead-end prognosis will yield very little compliance from patients for future treatments. Therefore, she says, "I rarely see a patient when I say, 'There's nothing more I can do.' I really feel it's better to give some hope — at least the hope that you will do all you can to help them live longer and feel better."

She says she refrains from discussing percentages and expected survivals unless the patient really presses. "Too many times you're wrong and you set yourself and your patient up for failure."

William D. Inglis, MD, chief of the department of medicine at Riverside Hospital and a hospice volunteer physician, agrees that setting time limits is a task far too sketchy. He says there are some very sick people who take good care of themselves and live longer than expected, and there are some people who do little to help themselves and die quickly.

In any case, "I try to get them to accept their illness and be very realistic about it. I try to be very accurate about what they have and what they should do about it," he says.

A specialist in pulmonary diseases, Dr. Inglis often treats patients in the latter stages of lung cancer. Honesty in these cases can be very raw. There are many times when he must say, "You have cancer. There is no cure."

But Dr. Inglis doesn't like to erase all hope. "I don't pull the carpet out from under them," he says.

Yet despite the hopes of certain treatments and cures, and no matter how compassionate and careful the physician, it probably does feel like the carpeting is being yanked from under these patients.

Sometimes, death is slow in coming — taking years, so that everyone from the physician to the family to the patient has adequate time to prepare. Other times it strikes abruptly, unexpectedly.

It is with this latter type that Dr. Whitacre most often deals, and, usually, that means breaking the news to unprepared relatives of the victim — the wife, the husband, or, in a fairly recent case, the parents of a teenage girl.

"This 16- to 17-year-old girl drove her car into a river and drowned." After she was brought into the emergency room, "another intern and I worked on her for about 45 minutes. Half of that time I think was more for us than for the child.

"I took the parents in while the code was going on so they could see their daughter before she died. I told them, 'I don't think we're going to win, but I thought maybe you'd like to see her.' After a certain point, the other intern and I just looked at each other like 'this is over.' "

Some situations are harder to forget than others. As Dr. Hodge notes, "What hurts is when the young die . . . when a person dies before his time."

But whether young or old, honesty still seems to be the best policy when presenting the news to the family.

"When you, as a physician, realize the patient has the potential of dying, you should be honest and you should tell the families that," says Dr. Whitacre — though this kind of honesty — the kind that hurts — is often very difficult to dish out, Dr. Whitacre admits.

"I can still remember telling one family that their father had died. It was the first time I was the responsible doctor. I'll never forget that."

Of course, "once you say they're dead, the next five to ten sentences you say they never hear," she says. Even so, she tries to give the family a little time, a little

comforting — whatever it takes, although this is sometimes difficult because "of the volume of people we see."

And because different people react differently, her approaches also vary, depending on the situation. "You really have to feel out the situation," she explains. "Sometimes you just sit there. Some you hug, some you hold their hand. I have trouble sometimes, too," she admits.

"You need to answer these people's questions as best you can. I try to give them a good, thorough explanation of what's happened — though not too technical."

Dr. Whitacre points out that it's essential for the family to understand exactly what happened, because sometimes they have ideas about the death that aren't always accurate. Some people think, "If only I could have brought them here two hours earlier they would have lived. You have to explain that nothing could have saved them. It's very necessary to help people get through it," she continues, "so they don't go away saying, 'that terrible hospital killed my relative.' "

And because the members of the family are the ones who bear the loss, Dr. Whitacre says, "I feel what I do for the family is as important as what I can do for the patient."

But dealing with families is almost always harder than dealing with patients, says Dr. Inglis. With patients, "I think if you're honest, most can handle it (dying) very well." But some families ask him not to tell the patient that he or she is going to die, he says. "I can't deal with that. I have to be honest."

A Fine Line

Because physicians deal so closely with life and death, questions often arise regarding just how *emotionally* involved physicians should become with their patients. On one level, they want to maintain a professional distance; but, on another, they want to make sure that this distance isn't construed as coldness or indifference.

Physicians have been hovering on this fine line for a long time. According to Dr. Hodge, "The physician can undergo an arduous balancing act in cases like this." On one side of the scale is the professional, matter-of-fact physician demeanor; on the other, is the emotional involvement developed by spending time with the patient and the patient's family.

"Physicians always have death at their sides," he continues. "Different people will handle it in different ways. Some are always aware of it, and others will deny it." Some physicians tend to get involved in the technical aspect of medicine, while others will ignore the problem by getting involved with drugs and alcohol, he points out.

"Doctors use a variety of defenses — professional distancing, humor, hostility, denial, resentment — any of the defenses human beings use to deal with something they don't like or that's hard to face," agrees Robert Whitehouse, MD, director of geriatrics for Mednet in Cleveland.

After all, "physicians are vulnerable to emotions just like everyone else," Dr. Hodge adds.

"You have to be able to distance yourself from your work," says Dr. Bechhold. "Otherwise, you would not be able to function, not be able to make decisions on what's

Confronting Death: How Physicians Deal with their own Mortality

Because physicians often deal firsthand with death, does it follow that they come to terms with their own mortality in a more immediate sense than others?

"You would think they would but they do not," Dr. Inglis says. "Physicians are just as human as anyone else, and most human beings have trouble coming to grips with death."

When it comes down to it, he continues, being able to accept death "is not related to intelligence, medical training or education."

Scientifically, death seems pretty pat: the cessation of life. But in an emotional and personal sense, death is not so easily pigeon-holed.

"Even though I may look at death and illness differently, I don't like it when my relatives die," Dr. Whitacre says. And, to be honest, "I'm not very sure about my own death," she adds.
— *Deborah Athy*

best for your patients."

But because Dr. Bechhold's specialty often requires that she develops ongoing relationships with her patients, often the balancing act is difficult to pull off. "Some people say, 'You're an oncologist; that must be depressing.' " It can be depressing, she admits, but it is also reassuring that she can help the patient and family through the ordeal.

"When I am talking to a patient, I am completely absorbed in helping that patient and their family. But once you leave that person, you can't dwell on the situation. I stop and think, 'How would I want my family treated?' I think if you really think about it that way it helps."

But walking that fine line between professionalism and compassion has its price and often takes a toll. "It does take extra time and it's emotionally traumatizing, but you have to do it. You can't ignore it . . . you owe it to the patient to respond."

Still, she says, there is a point when the physician has to know when to withdraw. "You give everything you can when you're in there with a patient, but you can't drag it behind you all day," she explains.

Achieving a balance between a professional and an emotionally responsive approach can be traumatic for physicians until they learn the difference between empathy and sympathy, says Dr. Hodge. Sympathy is actually putting yourself in the place of another, with the same wishes, fears and panics, he says. While empathy is "taking enough of a sample of these fears and panics, but maintaining a distance and objectivity."

Even so, after a long relationship has developed between physician and patient, maintaining this distance is easier said than done. When a patient dies, "it's always difficult," Dr. Inglis says. "I think of the majority of my patients as friends after I've seen them for a long time. You're supposed to be formal: they're supposed to be 'Mister'; you're supposed to be 'Doctor.' But it often doesn't work out that way. Every time one of my friends dies, a little part of me dies, though I'm comforted that I could help them through the dying."

Learning the Hard Way

"We get taught a lot about sickness, but not enough about dying," says Dr. Inglis. But death and dying *should* be given more emphasis in medical school, he says, "because doctors are going to deal with that one subject as much as they'll deal with anything else."

According to Dr. Jep Hostetler, director of Med I, Behavioral Sciences, at the Ohio State University College of Medicine, first-year medical students are required to take a class that encompasses death and dying, doctor-patient relationships and human sexuality. But beyond the first year, death and dying classes aren't mandatory, nor are they offered as electives.

Yet three or four years ago, such classes weren't even offered, so it appears that medical students are starting to get more of this kind of instruction than in the past.

Dr. Whitacre says the instruction she had on death and dying as a medical student was minimal, but she points out that a lot has changed since then — for one thing, writer Elizabeth Kubler-Ross came along and broke new ground in the death and dying issue, she says.

Still, it's really something "you sort of learn on the job," she adds.

"I just don't think death and dying is something you can teach in school," Dr. Bechhold says. "I'm not sure if you *can* teach someone how to be compassionate."

Perhaps to some extent this is true. One doesn't really learn the finer, more delicate points of dealing with death and dying in a classroom. It is rather that day-in, day-out coming-to-terms with death that is an education in itself.

Inevitability vs. Failure

Physicians must also learn — preferably early in their careers — not to take their patients' deaths as personal failures.

"If they're (doctors) overwhelmed by death, they're going to be out of practice in a big way," Dr. Hodge notes.

But the problem is that "some physicians enter the medical field with the idea of conquering disease and death. And so life and death become a personal battle. Every time someone dies, they've lost another battle — in the same way a lawyer loses a lawsuit," he continues.

"It is hard to deal with death," acknowledges Dr. Whitehouse. "But there is a certain point in your development as a doctor when you realize there are certain things you have no control over."

"I certainly can't save everyone," agrees Dr. Whitacre. "Sometimes I

know they're going to die no matter what I do. I had to learn to say, 'I did the best I could,' and not go home and think, 'I'm such a failure.' "

While in medical school, she and another intern vowed that a certain patient "wouldn't die on our blooming shift." But now she realizes that they were just playing a game. Gradually, she says, "You realize that part of the reason you're there is to help your patients die."

Physicians need to build up a little emotional scar tissue, says Dr. Hodge. Sort of a "suit of armor around the heart." A physician must understand that "he's really a human being; he's not God."

"I've long since given up taking it (death) personally, because I try very hard to do the best I can," Dr. Inglis says. After all, "everyone in the world is going to die. How could I take personal something that's inevitable?"

Why death seems so formidable

For one thing, it's *characteristically* hard to swallow. It's final, all-powerful, unexplainable and unpredictable. As Dr. Bechhold says, "It can come for anyone at any time."

"Most people are afraid of uncertainty," Dr. Whitehouse points out. And they associate uncertainty, as well as pain and desertion, with death.

But death isn't necessarily the negative experience it's cracked up to be, he says. In the near-death accounts reported by Kubler-Ross, people described carefree and tranquil sensations — feelings of warmth and of freedom from tension and responsibility.

And "for so many of my patients, it's a blessing," Dr. Whitehouse continues.

Nevertheless, "death is still looked on as the 'big enemy' " — for physicians and patients alike, says Dr. Hodge. "It would be helpful if death wasn't looked at like this, but was thought of as part of the process of growth and development over the lifespan."

Finally, maybe the real difficulty in accepting death has a lot to do with life, says Dr. Whitacre. "None of us think we want to leave here, because it's all we know."

Deborah Athy is the Journal's Editorial Assistant, and is the information specialist in OSMA's Department of Communications.

Funerals: Obligation or Choice?

In a recent article written in the *New England Journal of Medicine,* a geriatrics physician from Minnesota writes: "Somehow we must come to realize that our responsibility does not end with the pronouncement of death." The gist of the article maintains that physicians should attend their patients' funerals.

Other physicians have raised their pens in response to this view, writing that there are not enough hours in the day to attend their patients' funerals *and* to practice medicine, and that funerals are, in any case, a matter of personal choice.

"Literally every week one or more of my patients die," says Dr. Whitehouse. "Practically, I couldn't do it," he explains. "For the doctor who has a younger age group, perhaps it wouldn't be such a logistics problem."

"I do go to some funerals," says Dr. Inglis. "But I don't do it on a regular basis, because of my time commitment during the day."

Thus, time, or lack of time, seems to be the main element that makes attending patients' funerals impractical for many physicians.

While Dr. Hodge acknowledges that in many cases it is impractical, he says if a doctor has been treating a patient for many years and the time schedule allows it, attending patients' funerals "is generally a good idea."

In the same way that a physician advises a patient to tie up loose ends, perhaps attending a patient's funeral might help a physician to feel like "he's taking care of unfinished business, too," he adds.

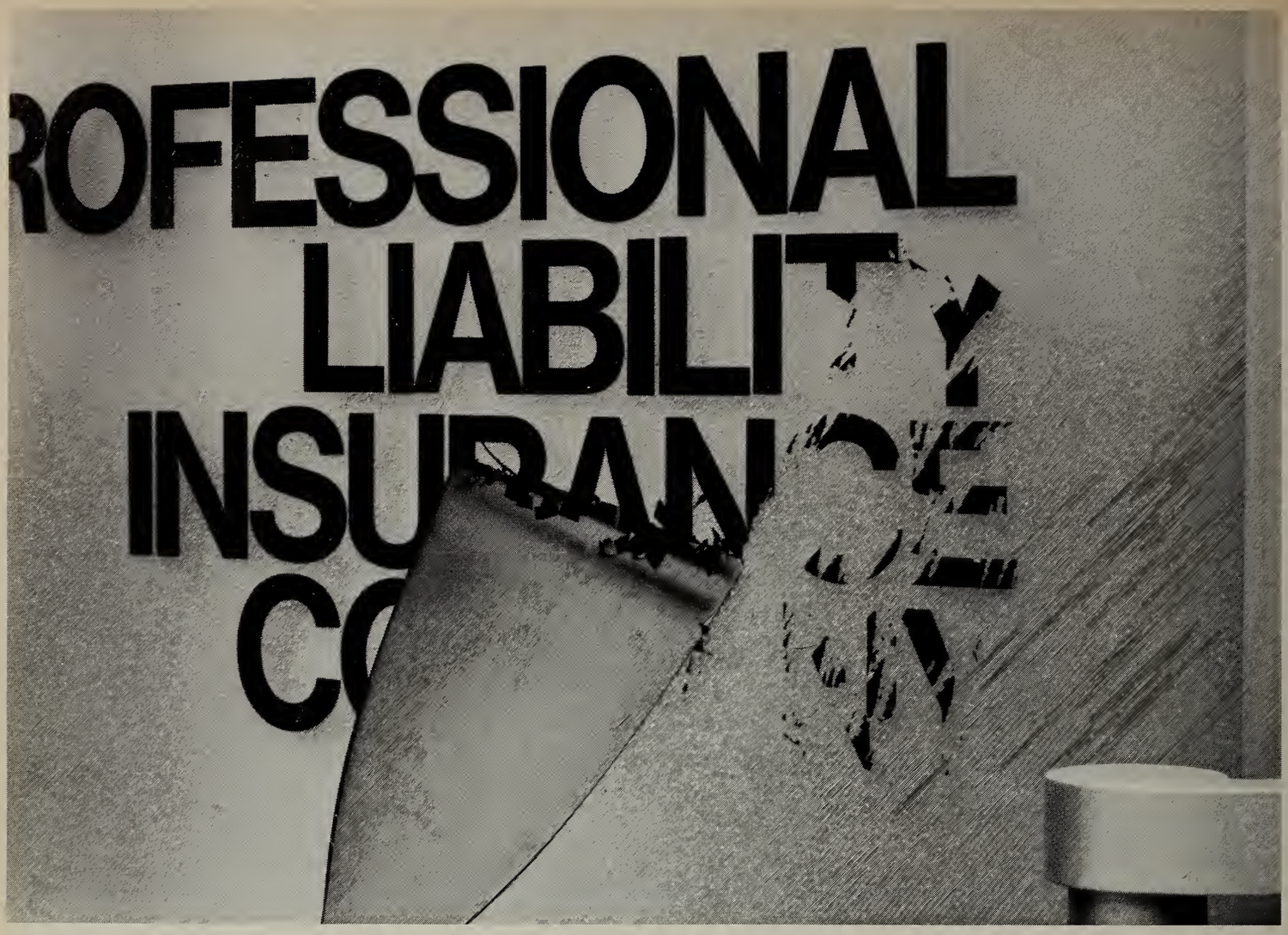
— *Deborah Athy*

Colleagues in the News

JAMES STEINER, MD, West Liberty, has been elected to a three-year term on the Adriel School Board of Trustees.

SANG M. SUH, MD, Coshocton, has been appointed health commissioner of Coshocton by the city board of health.

TERRENCE TULISIAK, MD, Medina, has been elected to the board of trustees of the American Heart Association Northeast Ohio Affiliate, Inc.



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AIDS:

The AMA's Action Plan Focuses on Education

The American Medical Association (AMA) is uniquely qualified to equip physicians with the knowledge they need about AIDS. Although some physicians have yet to be involved with treatment of an AIDS patient, all physicians encounter requests for information about AIDS from their patients and from the public. When questions and concerns about AIDS arise, they can be addressed best by individual physicians who are knowledgeable about AIDS and who understand the specific situation or circumstances of the individual seeking information.

The AMA's role, therefore, should be to disseminate information about AIDS to physicians and to establish physicians as the most credible, accessible source of AIDS information in the eyes of the public. To fulfill this role, the actions described below will be taken by the Association; in the event of limited resources, these actions will be prioritized and pursued to the extent resources are available.

AIDS presents a constantly changing environmental milieu in which the actions described below are to be taken. Changes in these actions may be necessary from time to time to assure relevance to immediate problems and needs.

Action items directed to the public are understood to be focused primarily through physicians serving as informational and guidance resources for their communities.

Education of Physicians

Provide current information on all aspects of AIDS through AMA publications, including *JAMA, AM News,* and others such as those of Sections for Hospital Medical Staff, Resident Physicians, Medical Students, and Medical Schools.

1. Council Reports and MMWR Reports on AIDS to *JAMA*
2. Special Books on AIDS: "AIDS from the Beginning"
3. Fednet Messages on new Developments
4. *AM News* Coverage of AIDS Information
5. Encourage AMA and other Publications to Increase Coverage of AIDS
6. Encourage increased Attention to Infectious Disease Control and Prevention in Medical Schools
   • Develop additional means of disseminating information about AIDS to physicians and state medical societies.
7. Identify quality Information from other Sources including State and County Medical Societies
8. Sponsor Tele-Conference with Expert Panel on Treating AIDS Patients (July '86 or later)
9. Consider Development of National Conference on AIDS Treatment — Possibly Link to Tele-Conference or Telecast (July '86 or later)
   • Alert physicians to fraudulent therapies, fraudulent prevention methods, etc., proposed for AIDS through Publications, Fednet, etc. Alerts about fraudulent AIDS information.
   • Develop procedural guides for physicians who care for AIDS patients.
10. Provide Practical Guidance to Physicians in Caring for AIDS Patients
    • Identify and network with other organizations, including state societies, involved with the AIDS issue and information resources for physician referral.
11. Develop Infection Control Guidelines in Concert with other Organizations Involved in Patient Care
12. Determine what other Specialty Societies Plan to Do About AIDS
13. Provide Representation at International AIDS Conference
14. Provide Speakers Bureau, and/or Videotape Updated

with major Developments (July '86)
• Provide a clearinghouse for information exchange among physicians, state societies and the AMA.

15. Develop in-house Sources of Information to Answer Physicians Questions
16. Referral of Physicians to Sources of Information about AIDS
17. Serve as AMA Interface for Information Exchange about AIDS with Other Groups Offering Information Clearinghouse
    • Communicate with officers of state societies about the AMA Action Plan on AIDS.
18. Send and update Action Plan to State Officers and Specialty Societies
    • Maintain commitment to the study of AIDS and related issues by the Council on Scientific Affairs and the Council on Ethics and Judicial Affairs.
19. Communicate with Councils Concerning Needs for AIDS Information

Education of the Public

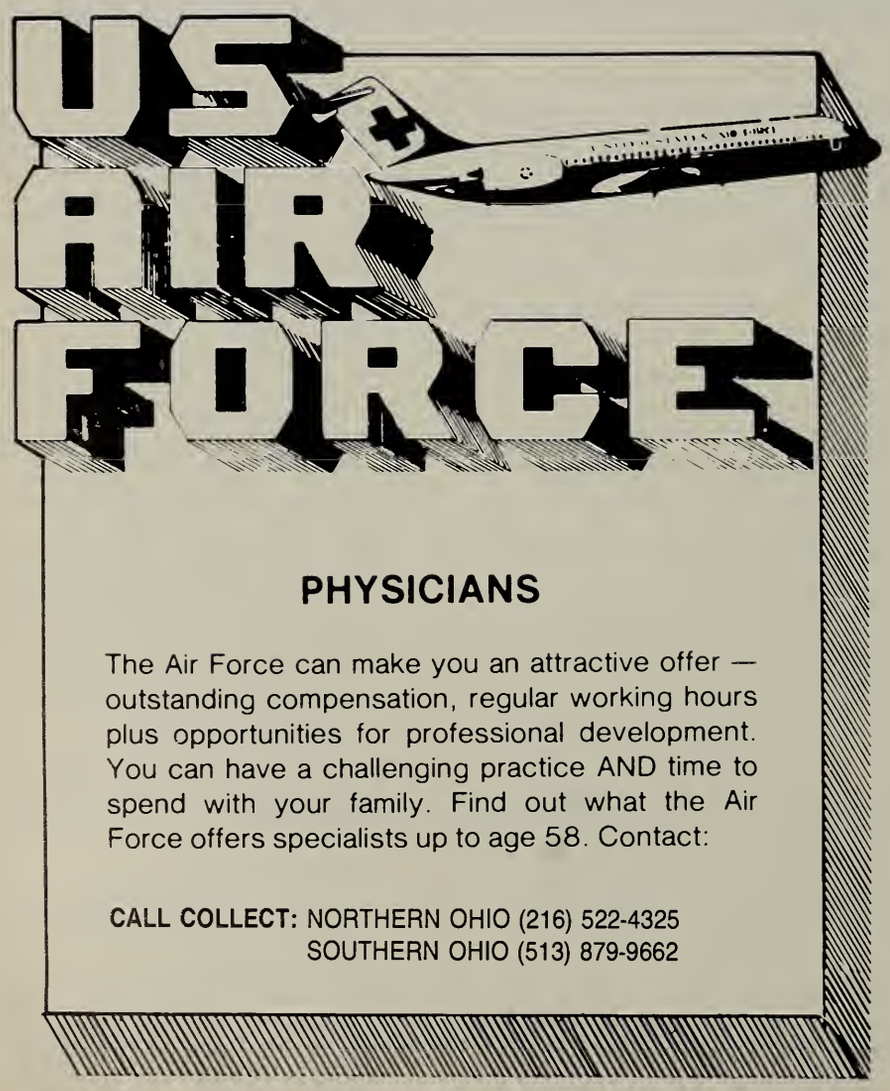
Inform public of AMA activities concerning AIDS.

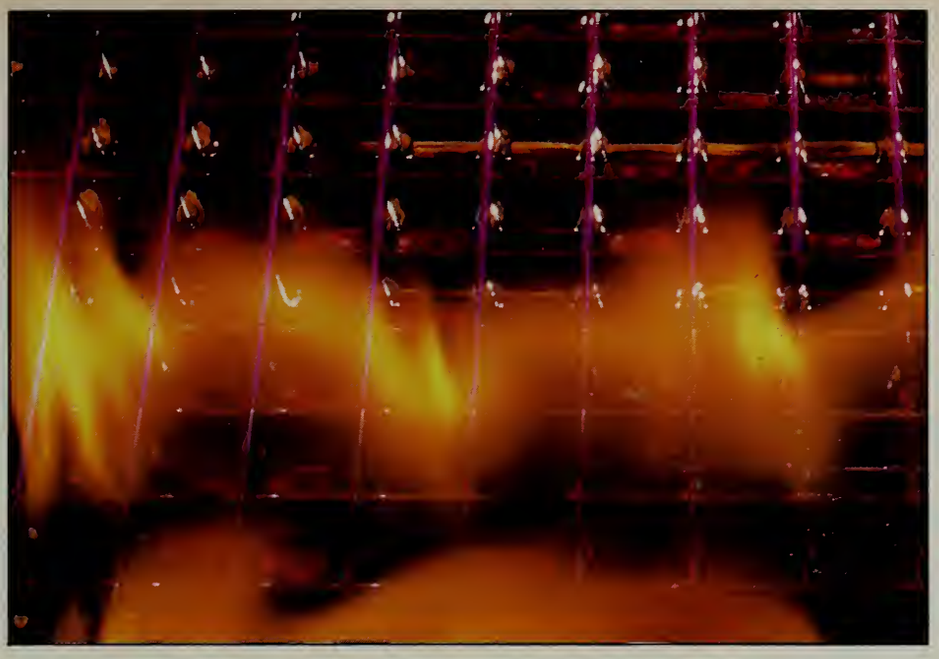
1. Encourage Publication of Articles in Public Media concerning AMA/AIDS activities.
   • Share information about AIDS with the public through the AMA Auxiliary.
2. Encourage Physicians and Auxiliary Members to Serve as Educators about AIDS in their Communities
3. Provide Information about AIDS to Auxiliary for Dissemination to Membership
   • Develop pamphlets about AIDS for physicians offices and for other outlets.
4. Develop Pamphlets and Marketing Program for Pamphlets
5. Develop Guidelines for Public Service Employees, Public Health Officers, etc., for Dissemination through their Organizations
   • Identify additional methods to disseminate information about AIDS to the public.
6. Target Information to Allied Health Care Personnel — Possibly through CAHEA
7. Develop Infection Control Message and Guidelines for Home Care of AIDS Patients
8. Inform Public about AIDS through "Medicine Today" and "American Medical Radio News"
9. Develop Mechanisms to Facilitate Dissemination of Accurate Information about AIDS in Public Media
   • Encourage state medical societies, medical schools, medical students and resident groups to increase their role in serving as advocates for AIDS patients, in educating the public about AIDS, and in interfacing with state agencies with regard to issues and policies surrounding AIDS.
10. Communicate with Appropriate Groups Concerning these Issues
    • Continue to monitor AIDS research, funding and legislative actions.
11. Implement Monitoring Program

AMA Policy on AIDS

• Review and develop AMA Policy on AIDS.

12. Review Existing Policies and Suggest New Policies on AIDS for Appropriate Councils, BOT and HOD, with Target Date for Adoption of I '86.





Medical Professional Liability — A Second Crisis?

By Susan Porter

Editor's note:
This article is the second in a series of articles on the new professional liability crisis.

It has been over a decade since James L. Henry, MD, put down his gavel as president of the Ohio State Medical Association and assumed the chairmanship of a new OSMA task force charged with resolving one of the most severe crises to ever face the medical community: professional liability. Dr. Henry's 1974-1975 OSMA presidency had been plagued by the fact that virtually overnight Ohio physicians were finding their malpractice insurance premiums had doubled, tripled and quadrupled — or worse yet, that their policies were being cancelled altogether.

"There was a real crisis on," Dr. Henry recalls.

Thus early in 1975, a letter went out to all OSMA members explaining the critical nature of the situation and asking for help and suggestions. By the end of February, another communication was issued, asking membership support for "plans for sound, lasting, unified, remedial action" — namely, seeking major changes in Ohio law regarding the way professional liability cases were being accepted, heard and resolved.

At the OSMA's 1975 annual meeting, a host of resolutions were passed seeking a remedy to the situation and charging a committee with investigating, evaluating and taking appropriate action on the situation. Following the installation of Maurice F. Lieber, MD, as the 1975-1976 OSMA president, Dr. Henry was appointed to head the new OSMA Task Force on Professional Liability.

Among the issues the task force was charged with investigating were availability and reasonable pricing of professional liability insurance, arbitration, limitation of awards, contingency fees, and professional and public education.

It is little wonder, therefore, that Dr. Henry has a sense of deja vu as he sits at the head of a newly reorganized Task Force on Professional Liability, taking



another hard look at matters such as limitation on damages, arbitration, contingency fees, collateral source rule, and statute of limitations.

It was the original task force that 10 years ago helped to put together the legal and legislative package that resulted in H.B. 682, the major legal framework under which malpractice cases are still decided in Ohio today (see related story). Also resulting from that task force's recommendations was the formation of the Physicians Insurance Company of Ohio (PICO), Ohio's physician-owned professional liability company which now insures nearly 40 percent of the doctors in the state.

The task force has continued to meet periodically over the years, says Dr. Henry, and to monitor the malpractice situation in Ohio, in order to make sure that adequate, affordable coverage remains available to all Ohio physicians. Several years ago, the task force commissioned a study by the certified public accounting firm of Peat, Marwick, Mitchell & Co. to analyze the medical malpractice insurance providers in Ohio and to assess the likelihood of a new crisis.

Among the report's major conclusions: "The market has enough participating insurers that, even if financial problems affected one insurer, coverage would continue to be available, albeit at a higher cost. On the other hand, financial problems extending to the reinsurance market could affect the availability of coverage."

Not until last year, however, was the OSMA Task Force on Professional Liability fully reactivated, with over 20 new members added to its ranks. "Today we have a lot more of our membership involved," says Dr. Henry, "and we have a greater representation of specialties and geographic areas in the state."

Following another cluster of resolutions concerning professional liability at the 1985 OSMA annual meeting, Dr. Henry's committee again was asked to actively consider legislative and other proposals to control the rising costs of professional liability insurance and the rising costs of "defensive medicine" that resulted. The task force also has been reorganized into four subcommittees, each charged with specific tasks that will lead to developing a new package of tort reforms the group hopes to see introduced in the Ohio Legislature early next year.

It was only a matter of time, says Dr. Henry, before the new laws that came about as a result of the last professional liability crisis would need to be reanalyzed and reworked. "In fact, in some ways," he says, "we're surprised that it has taken 10 years."

The Second Crisis

Once again, the medical community is facing a professional liability crisis. While in Ohio it has not yet reached the dimensions of the mid-1970s crisis, there already is reason for concern, Dr. Henry and others closely following the situation believe.

Perhaps the most obvious sign of a problem is the continuous rise in professional liability rates, particularly for those high-risk specialties such as neurology, orthopedic surgery, ob/gyn and plastic surgery. Two years ago, these individuals were paying generally between $6,000 and

$9,000 per year in premiums in Ohio (depending on the amount of coverage). Today they are paying between $17,000 and $26,000 per year, with all major carriers hiking premiums by substantial amounts.

Even those low-risk specialties such as family practice, internal medicine, radiology, dermatology and ophthalmology have seen their premiums increased by about 65 percent, and are now paying between $1,900 and $3,000 per year. And virtually all physicians serving on hospital medical staffs are feeling the bite of the so-called $1 million umbrella, as companies that insure hospitals demand that all medical staff members purchase at least a million dollars worth of liability insurance in order to retain their privileges.

Unfortunately, "the whole situation keeps getting worse and worse," says William M. Wells, MD, medical director at PICO. "Today we are seeing more claims and higher awards for medical malpractice cases than we've ever seen before," he says. Last year, for example, some 1,440 claims were filed against PICO policy holders, as compared to 125 in 1977. And today, malpractice settlements have reached such heights that "it's not unusual for a physician to be sued for a claim that is far greater than he or she will earn in a lifetime," says Dr. Wells.

To date, the highest single claim paid out by PICO was $1.1 million. Yet other cases are pending, reflecting a nationwide trend in multi-million dollar suits. Thus, the only way that insurance companies can protect themselves and their clients is to raise their rates, so that adequate reserves are available, both for now and for the "long-tailed claim" — that claim against a physician that won't be filed for several years down the line.

Today's crisis, therefore, is one largely of affordability — which may eventually lead to another crisis of availability, Dr. Henry says. Already, St. Paul Insurance, which carries the policies of over 6 percent of the physicians in this state, has announced it will not write any new policies for physicians, hospitals, nursing homes or other health care providers. Those already insured will see their premiums increased by 45 percent, the company says.

PICO, like the seven other companies which handle professional liability coverage for Ohio physicians, has raised its rates twice in the past two years, and it continues to take a conservative stance in the marketplace to make sure there are adequate reserves to cover its claims. Since 90 percent of PICO's total business is in professional liability, it will not close its doors on doctors, as the other more diversified companies did a decade ago.

However, as the 1983 Peat Marwick report entitled "Analysis of Medical Malpractice Insurance Providers in Ohio" pointed out, it is the reinsurers who may be in trouble. And it's not just physicians who are at risk of having their insurance rates raised or cancelled as a result of the current liability crisis.

"Given the litigious nature of American society these days, just about any kind of business, profession or government agency is likely to become the target of a suit alleging malpractice or negligence resulting in personal injury," states an article in the March 24, 1986 issue of *Time* magazine. "That makes liability insurance, the kind that pays off on such claims, just about as vital as oil in keeping the economy functioning. But in the past two years, liability insurance has become the kind of resource that oil was in the 1970s: prohibitively expensive, when it can be bought at all."

The Nature of the Problem

Just a generation ago, physicians practicing in this state — and in the rest of the country — gave little thought to the matter of professional liability. Malpractice insurance was purchased largely as an afterthought to auto, property and life insurance, and often was included in the same package, since only a handful of physicians would face the prospect of a lawsuit during their lifetimes.

Today, "a physician just starting out in practice cannot expect to get through his or her career without being named in a lawsuit," says John Vance, former senior vice president at PICO and now president of American Physicians Life, while physicians in certain high-risk specialties can plan to be sued several times during their years of practice. What has happened over the last three decades to change the prospects so dramatically?

Part of the problem can be traced back to the World War II era and the development of modern technology and new drugs which dramatically altered the practice of medicine. Suddenly the public's hopes and expectations soared as physicians were able to prevent illness and save lives.

Today, these high expectations have evolved into an out-and-out

Liability . . . A Second Crisis? . . . *continued*



demand for one-hundred-percent-guaranteed medical care, so that when something goes wrong, it is automatically assumed that someone is at fault — and that someone should have to pay. This is particularly true in obstetrics, where a physician and his/her insurance company may be expected to pay a settlement large enough to support a deformed child for a lifetime.

"If someone has a malformed baby, that doesn't automatically mean there was malpractice involved — in fact in most cases it doesn't even approach malpractice," says David A. Barr, MD, the head of one of the four liability task force subcommittees. Among the topics Dr. Barr's subcommittee is addressing is the special liability crisis now faced by ob/gyns. In some states, obstetricians are paying as much as $130,000 a year for malpractice coverage, forcing many to change specialties or to retire from medicine altogether.

"And yet if you bring a malformed baby into the court room, there isn't a jury in the world who won't sympathize with the parents," Dr. Barr says — even if no one is at fault.

Coupled with that sympathetic attitude is a kind of get-rich-quick public mindset that spills over into other types of liability as well. "A person is in an automobile accident and so he or she sues the auto manufacturer because the seat belts didn't work right or the car didn't handle like expected," says D. Ross Irons, MD, chairman of the Education and Coalitions subcommittee of the OSMA Task Force on Professional Liability. And rather than simply seeking compensation for out-of-pocket expenses related to the accident, the individual goes for "the big hit," in Dr. Irons' words, or the maximum award a jury will give.

It is this combination of "winning the lotto" and "there but for the grace of God go I," says Dr. Irons, that has led to more cases and higher awards in the courts. But what many members of the public don't realize, Dr. Irons continues, is that "they are only hurting themselves."

The situation is driving health care costs out-of-sight, he says, due not only to the higher malpractice insurance premiums physicians are being forced to pay but also because of the extra tests, paperwork and clinical support they are using to protect themselves. "Defensive medicine," says Dr. Irons, "is costing the American public between $30 billion and $60 billion a year."

The situation also is forcing a number of highly trained specialists out of practice or into early retirement and is having a negative impact on the development and use of new drugs and technology. But the ramifications go beyond medicine, he adds.

"This permissive and litigious attitude is creating a very unstable atmosphere and is having its effect on every type of insurance offered today," says Dr. Irons. "Medical professional liability is just one part of an international liability crisis that threatens not only the cost and availability of medical care, but also a person's ability to purchase home insurance and to continue driving an automobile. In addition, city parks are closing, special events are being cancelled and YMCAs are being forced to give up summer camps and day care programs — all because they

can't get liability insurance, Dr. Irons adds.

Physicians Are Not Alone

Perhaps the biggest difference between the professional liability crisis of today and that which surfaced a decade ago, Dr. Irons and others point out, is that in 1975 physicians were alone in their struggle to find insurance carriers and to pay the increased premiums. Today, however, the crisis threatens a much broader base in society, including not only health care providers but also the owners of restaurants, theaters and department stores, as well as public officials, manufacturers and even attorneys.

"We are no longer the lone rangers," Rick Ayish, director of the OSMA Department of Legislation, told physicians attending a professional liability-specialty society update meeting held at OSMA headquarters in March. "Today we have lots of company — and a significant number of legislators are sympathetic to our problems."

The problem hit home with one Ohio legislator, says Ayish, when the recently elected official was informed he could not hold a celebration party at his church, because the church couldn't afford to carry the extra liability insurance. "Legislators are becoming much more educated about the problem," he says, "and this is creating a snowball effect."

This sudden awareness of and interest in the situation is encouraging — but it also has its drawbacks, Ayish says. While broad-based support is critical to passing any kind of major tort reform, it is important that all aspects of the current liability situation be fully analyzed and carefully documented before the matter comes before the Ohio General Assembly.

"We are basically looking at a two-tiered approach to the problem," Ayish explains. "Our preferred approach is a long-term strategy which would give us time to study all the issues involved, collect the data we need to support our case, educate both physicians and the public about the problem, and put together a package of reforms that would be introduced in the Legislature in January of 1987."

In addition, says Ayish, 1986 is an election year for many legislators who will be out on the campaign trail, and, thus, will be unable to give full time and consideration to the many complicated facets of the current liability crisis. "We do not want to see this become an election-year issue," he says.

However, a short-term strategy also has been devised, should a number of those tort reforms being sought by the OSMA task force first be introduced by other groups affected by the current liability crisis. Already a significant number of legislative proposals have been introduced before the Ohio General Assembly, including reform packages supported by the state's civil defense attorneys and by Ohio's insurance companies.

"We are following these packages very carefully and we are lending our support to these efforts," says Ayish. "At the same time, we are preparing our own package that will deal with those issues pertinent to medical professional liability."

Meanwhile, the task force and its subcommittees are continuing to work in their respective areas to make sure that the action taken will meet the needs of Ohio's physicians. The first subcommittee, headed by Dr. Irons, centers on Education and Coalitions. Its purpose is "to build a broad-based coalition, representing physicians, osteopaths, allied health care providers, hospitals and perhaps even outside groups, such as manufacturing," Dr. Irons explains. "We have already contacted the different groups involved, and we now have a certified coalition with the Ohio Hospital Association and the Ohio Osteopathic Association, which will formally represent our concerns throughout this process."

A second task before this subcommittee is to educate both physicians and the public regarding the full ramifications of the crisis. While physicians can be informed and updated through OSMA publications, "special brochures and other communications from the task force, educating the public could take as much as $5 to $6 million to do the job adequately," says Dr. Irons. This, he adds, is another reason why broad-based support from other groups affected by the current liability crisis will be needed.

The second subcommittee, under Dr. Barr's chairmanship, is looking at specific subjects which directly affect the premiums Ohio physicians are paying, including Structured Settlements, Limitations on Damages and Statute of Limitations, along with the special ob/gyn situation. While most of these areas can be addressed effectively through legislative reform, the last item, says Dr. Barr, "is really not a malpractice problem but society's problem —



and one that society is going to have to address."

Donavin A. Baumgartner, Jr., MD, is heading a third subcommittee which is looking at Arbitration, Contingency Fees, Counter Suits and Collateral Source Rule. According to Dr. Baumgartner, a detailed report already has been prepared by that subcommittee, along with specific recommendations for legislative action on each item.

The fourth subcommittee is headed by A. Burton Payne, MD, a past OSMA president who has served on the professional liability task force since its inception 10 years ago. Dr. Payne's subcommittee is in charge of Legislation and Strategy and is seeking the best approach to bringing this newest package of tort reforms before Ohio's lawmakers.

"Ten years ago, we managed to get a lot of tort reforms through," says Dr. Payne, "but we've lost a lot of them over the years because they weren't acceptable to the Ohio Supreme Court in the form in which they were passed."

Dr. Henry agrees that while a fresh new look is currently being taken at the entire professional liability situation in Ohio, much of the work of the task force is simply reworking and redoing what was done 10 years ago. "There's been a lot of erosion of these laws," he says. "Right now we are seeking new legislation that will bolster those parts of the previous package that worked successfully in the past."

Another professional liability crisis does exist in Ohio, says Dr. Henry. But, in many ways, Ohio physicians are much better off than doctors practicing in a number of other states. A recent report, for instance, indicated that while New York doctors now pay an average of 10.2 percent of their gross revenues in malpractice insurance premiums, Ohio's doctors still pay only 2.7 percent — or an average of $5,114. "A lot of states are just now accomplishing what we were able to do 10 years ago," he says, referring to the numerous tort reforms now underway in other parts of the country.

In addition, says Dr. Henry, the OSMA Task Force on Professional Liability today is much better equipped to deal with the problem than it was a decade ago when "we were all neophytes. Now we have some experience — and some guidelines. As a result, I think we will come up with an even better package than we did before." **OSMA**

Susan Porter is the Associate Editor of the Ohio State Medical Journal.

Colleagues in the News

S. MARCUS WIGSER, MD, a neurosurgeon from Providence Hospital, has been elected president-elect of the Academy of Medicine of Cincinnati.

NICHOLAS D. WING, MD, head of the Department of Internal Medicine at Akron General Medical Center, has been elected Secretary-Treasurer of the American Group Practice Association.



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Notable Quotes

"We, as a society, seem to be pretending that consumers live in a totally risk-free environment — that they must be not just compensated but rewarded for any injury." — John E. Fisher, General Chairman, Nationwide Insurance *(in an article in the Columbus Dispatch).*

Psychological health in children

Pediatricians, family practitioners and other primary care physicians who treat children frequently can aid in the effort to spot psychological problems early, according to one child psychiatrist.

Michael Jellinek, MD, assistant professor of psychiatry at Harvard Medical School, suggests that during a regular checkup, physicians ask children a couple of age-relevant questions about each developmental area in order to detect potential problems.

These questions center on five functional areas of a child's life — school, play, friends, family and general mood. Dr. Jellinek, who also is the chief of child psychiatry at Massachusetts General Hospital in Boston, currently is developing a screening questionnaire which could be used by the physician during the child's annual physical.

In younger children, parents would answer the questions about their child's functioning, while in older children and adolescents, the child could answer the questions.

According to Dr. Jellinek, between 30% and 50% of pediatric office visits can concern psychosocial or developmental issues. Due to the high divorce rate in this country and other childhood stresses, psychological problems are more prominent in children today, he adds.

Because parents often are too close to the problem, they may not be able to detect these problems in their children. However, the physician is in a key position to help identify those children at risk who might later develop more serious problems such as suicidal tendencies and drug or alcohol abuse problems.

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Diabetic Retinopathy Update for the Primary Care Physician

By Alan D. Letson, MD

The Problem:

Diabetes remains the leading cause of new blindness in the United States with nearly 5000 new cases of blindness being reported annually.[1] Historically, the incidence of diabetes approximates 2 percent, but a trend to increasing incidence has been identified over the past several decades.[2] Some of this increase may be due to better screening and diagnosis, while there is a real increase due to the increased longevity of the diabetic population, as well as increased longevity of the general population (greater prevalence of diabetes in the elderly). Diabetic retinopathy will ultimately affect many of these patients creating a continuing demand on both personal and public resources from the significant medical and social morbidity of this condition. Data from the Diabetic Retinopathy Study Research Group have shown significant improvement in visual prognosis when photo-coagulation is used for treatment of proliferative and background retinopathy.[3,4] As it appears that visual prognosis improves with early treatment, it is imperative that all physicians be familiar with the manifestations and diagnosis of this devastating condition.

Who will develop diabetic retinopathy?

At least two major factors influence the frequency of diabetic retinopathy. The first is the duration of diabetes. The second factor is age of onset of diabetes. Patients diagnosed before the age of 30 will have a longer interval between diagnosis of diabetes and retinopathy compared to those patients whose diabetes is diagnosed after age 30. After 10 years of diabetes about 50 percent of these younger patients will develop retinopathy; at 20 years duration over 75 percent will manifest retinal disease. For patients in older age groups the duration of diabetes until the development of retinopathy is shorter; however, this is most likely due to a period of clinically unrecognized diabetes in this population. For both groups a frequency of 75 to 80 percent for retinopathy is seen after 20 years of diabetes.[5] Although the terms "juvenile onset" and "adult onset" have been replaced, these references to age of onset still have meaning in regard to the type of retinopathy that may be seen. Although background retinopathy and proliferative retinopathy are seen in both groups, the "juvenile onset diabetic" tends to develop proliferative disease while the "adult onset diabetic" shows a greater frequency of background retinopathy. Background retinopathy in a juvenile onset patient is often a preview to the development of proliferative changes. About 20 percent of adult onset diabetics with retinopathy will develop proliferative disease. In general, the severity of background retinopathy seems worse in older adult onset diabetics.

The presence of hypertension is another risk factor for diabetic retinopathy,[6] and the presence of uncontrolled hypertension and renal disease significantly worsens the prognosis for vision.

Diabetic retinopathy . . . *continued*

From what is understood about the pathogenesis of diabetic retinopathy, it would seem that rigid control would correct the multitude of metabolic abnormalities that ultimately lead to the blood vessel changes seen in the retina. Early studies involving the use of insulin infusion pumps were discouraging; however, many of the patients in these early trials had pre-existing or advanced retinopathy before the use of the infusion pump. More recent studies where infusion pumps have been used in patients with no or mild retinopathy have suggested that rigid control may retard the development of microangiopathy.[7] It seems that once retinopathy develops, control of blood sugar becomes less significant in the course of retinopathy.

What causes diabetic retinopathy?

It is understood that hyperglycemia results in numerous metabolic abnormalities including increased levels of glycosylated hemoglobin and decreased levels of 2,3,-DPG which increase oxygen affinity to the hemoglobin molecule resulting in tissue hypoxia. In addition, there are associated abnormalities in serum proteins, fibrinogen, prostaglandins, and growth hormone, all of which increase red blood cell and platelet aggregation and adhesion. Sludging and stasis of blood flow are the result, which adds further vascular injury. These metabolic abnormalities, sludging blood flow and hypoxia, ultimately damage the retinal capillary wall (more specifically the capillary endothelium) resulting in permeability changes, capillary closure and retinal ischemia. These are the insults that lead to the visible findings seen on ophthalmoscopy and fluorescein angiography.

What are the symptoms of diabetic retinopathy?

Vision which fluctuates over a cycle of days is most often due to varying levels of hyperglycemia which result in osmotic lens changes which will alter the patient's refractive error (a myopic shift). A cataract can cause a gradual progressive loss of vision and may be accompanied by a complaint of glare. Background diabetic retinopathy becomes symptomatic when macular edema develops and these symptoms consist of gradual progressive loss of central vision. Many patients will complain of reading difficulty and describe their central vision as if they were looking through a dirty window, an oil smear, or a film. Colors may seem dingy or washed out. If the maculopathy is advanced, a central blind spot may be described. The vision with background retinopathy may also fluctuate, but there tends to be a steady downhill trend.

Patients with significant proliferative retinopathy may be asymptomatic! Patients with proliferative disease often have background disease as well and will have complaints related to macular edema as described above. Patients with proliferative retinopathy will also complain of difficulty seeing at night and some may note decreasing peripheral vision. The most significant symptoms of proliferative disease include the presence of new floaters, "strings," or "cobwebs" due to mild vitreous hemorrhage, or sudden dramatic loss of vision due to vitreous hemorrhage or retinal detachment. Pain is not a symptom of diabetic retinopathy unless the patient has severe proliferative retinopathy and has developed neovascular glaucoma as a result of severe retinal ischemia.

What does diabetic retinopathy look like?

The earliest visible changes in background retinopathy include mild venous dilatation and microaneurysm formation. Microaneurysms appear as discrete, punctate red dots within the retina. These lesions are important sources of leakage which can often result in loss of vision from macular edema. Not all microaneurysms that are clinically significant can be seen with the ophthalmoscope and, therefore, must be identified with fluorescein angiography in order to be included in a laser treatment. "Dot" and "blot" hemorrhages are also present in the early stages of retinopathy and are larger and less discrete than microaneurysms.

As background retinopathy progresses, changes in capillary permeability and perfusion become more prominent. With increased capillary permeability there is more leakage of serum from microaneurysms and damaged capillaries that will result in swelling (edema) in the retina and the deposition of lipid and protein which is seen as hard exudates. When edema or exudate involve

the fovea, the patient may begin to complain of decreasing central visual function. On ophthalmoscopy, the loss of the foveal light reflex will indicate the presence of foveal edema. A chronic presence of edema or hard exudate in the fovea will ultimately result in structural damage to the retina and a permanent loss of vision.

Cotton wool spots appear as white patches in the superficial nerve fiber layer of the retina. On fluorescein angiography these correlate to areas of capillary bed closure and retinal infarction. Nerve fiber layer hemorrhage (flame shaped hemorrhage) frequently accompanies cotton wool spots and is often a sign of ischemic change due to progressive capillary infarction, uncontrolled hypertension, and/or renal disease.

As background retinopathy worsens, so do the patients' complaints of poor central visual function, and, ultimately, legal blindness or worse results from chronic edema, heavy exudation, crystal formation and ischemia.

There is a stage of retinopathy referred to as preproliferative retinopathy that consists of background changes as noted above, but there are additional features that characterize this condition: a greater proportion of cotton wool spots and nerve fiber layer hemorrhages, venous beading, in which the retinal veins become markedly dilated in a segmental sausage link fashion, and IRMA (intraretinal microvascular abnormalities) which are dilated intraretinal capillaries and shunt vessels. This fundus appearance represents significant hemodynamic alteration in the retina and is a precursor to proliferative retinopathy.

Proliferative diabetic retinopathy is characterized initially by neovascularization of the optic disc (NVD) or retinal surface (NVE). These membranes of new vessels consist of fibrovascular tissue which matures to form sheets of dense scar tissue which are adherent to both the retinal surface and vitreous gel. Contraction of the fibroglial elements results in vitreous hemorrhage and traction retinal detachment. Neovascularization can be easily appreciated by careful examination with the direct ophthalmoscope. These vessels appear as fine wispy nets of capillaries on or arising from the retinal or optic nerve surface. Often the vessels may be elevated and can be missed unless various focal planes are checked with the ophthalmoscope. Key areas to be examined include the optic disc and the major retinal vascular arcades. As neovascularization tends to occur near the venous side of the circulation, it is helpful to follow the veins along the major arcades. Most retinal neovascularization occurs along the temporal venous arcades and in the temporal inter-arcade zone. Another key area is a circumferential zone in the midperiphery of the retina. This area is more difficult to visualize, but can be done by having the patient look in the direction of the area to be examined, i.e., look up when the superior midperiphery is to be examined.

Proliferative retinopathy can be categorized prognostically by identifying risk factors for severe vision loss.[8] The risk factors are additive and include: 1) the presence of any new vessels 2) new vessels on or within one disc diameter of the optic nerve 3) NVD greater than 1/4 disc diameter or NVE greater than 1/2 disc diameter and 4) any preretinal or vitreous hemorrhage. Without laser treatment, an eye with four risk factors has a 36.9 percent chance of severe visual loss (5/200 vision) in a two year period of time.[8]

What is the treatment for diabetic retinopathy?

Hyperglycemia should be brought under control with appropriate diet, insulin and/or antihyperglycemic agents, and any hypertension should be rigorously treated. The mainstay of therapy, however, is the use of photocoagulation.

Laser photocoagulation for background diabetic retinopathy consists of coagulating individual microaneurysms that have been identified by fluorescein angiography as being sources of leakage. In cases of diffuse leakage, diffuse grid patterns of photocoagulation scars are sometimes helpful in reducing retinal edema. Because edema and exudate in the fovea can cause permanent damage to the retina, early detection and treatment provide the best opportunity to preserve eye sight. Only during early stages of macular edema can visual improvement be achieved with laser treatment. The prime objective of laser treatment is to preserve remaining vision and prevent further loss.

Indications for laser treatment for background retinopathy

Diabetic retinopathy . . . *continued*

include hard exudates and/or retinal edema in or within a disc diameter of the fovea. These criteria may include patients with 20/20 vision; however, if left untreated, background retinopathy produces progressive loss of vision which may not be retrievable. Generally, good visual acuity, focal leakage, and absence of hypertension are prognostically favorable, while poor vision, hypertension, diffuse leakage, heavy exudation in the fovea and cystic degeneration carry a poor prognosis.

Laser treatment for proliferative diabetic retinopathy requires more extensive ablation of the ischemic midperipheral and peripheral retina. By selectively destroying ischemic retinal tissue not critical to central vision, the reduction in ischemic tissue results in improved blood flow properties, increased oxygenation of the retina, and a decreased metabolic/chemical stimulus for new vessel growth. Ultimately, the new vessel growth regresses or stabilizes. Overall, the incidence of severe vision loss due to proliferative retinopathy can be reduced by over 60 percent with laser treatment. It should be pointed out that laser treatment is not a cure for diabetic retinopathy, just as insulin is not a cure for diabetes. Side effects of panretinal photocoagulation for proliferative retinopathy include constriction of peripheral vision, poor dark adaptation, pupillary mydriasis, loss of accommodation, mild discomfort that may last several weeks, and blurred vision which about 10 percent of the time does not completely resolve. Overall, the undesirable effects of laser treatment are far outweighed by the poor visual prognosis of an untreated eye. Unfortunately, there are a significant number of eyes with advanced retinopathy that will not respond to laser treatment and ultimately become blind.

What is the role of the primary care physician in diabetic retinopathy?

The primary care physician is in an ideal situation to begin at least basic patient education concerning this important complication of diabetes. Frequent contact with the patient also affords multiple opportunities to examine the optic disc and posterior pole for signs of retinopathy. Attention to even minor visual complaints in patients with risk factors for retinopathy can lead to timely referral for evaluation by an ophthalmologist. Detection of exudate, retinal edema or new vessels is of prime importance for instituting prompt care. When retinopathy has been diagnosed, attention to diabetic control and rigorous management of hypertension and renal disease may minimize retinal damage. Generally, every diabetic should have complete ophthalmologic evaluation annually, if duration of disease is five or more years. The primary care physician can be a major link in the education and early detection of diabetic retinopathy.

Alan D. Letson, MD, is a Columbus ophthalmologist whose practice is limited to vitreo-retinal diseases.

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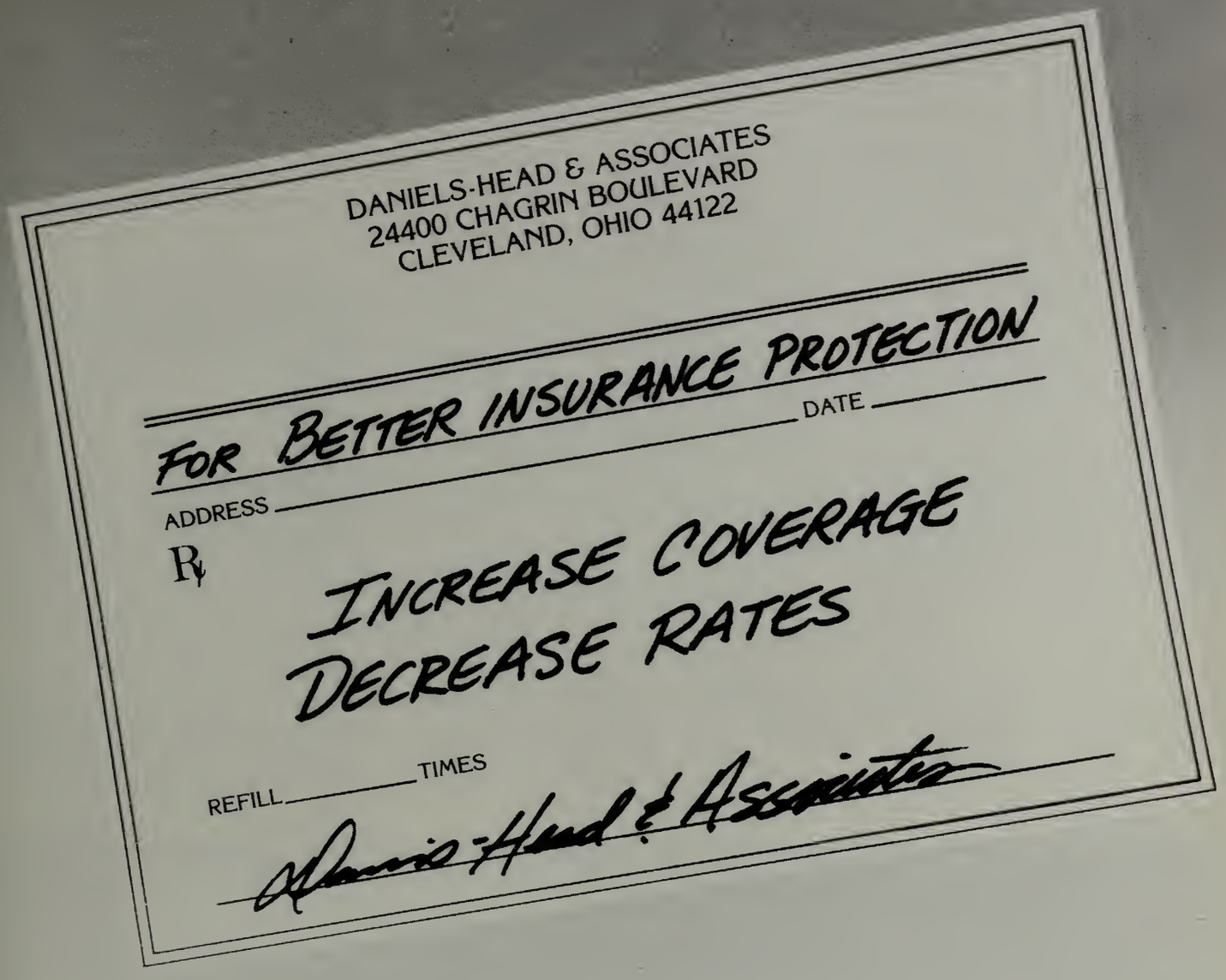
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Colleagues in the News

RICHARD H. BELL, JR., MD, associate professor of surgery at the University of Cincinnati Medical Center, was recently elected secretary-treasurer of the Association for Academic Surgery.

RALPH E. BERGGREN, MD, has been appointed vice provost for Academic Affairs and executive associate dean of the Northeastern Ohio Universities College of Medicine.

RANDALL L. BRADDOM, MD, director of Physical Medicine and Rehabilitation at the Providence Hospital in Cincinnati, was recently elected vice president and newsletter editor of the Association of Academic Psychiatrists.



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Obituaries

GARRY G. BASSETT, MD, Cleveland; Case Western Reserve University School of Medicine, 1933; age 76; died March 16, 1986; member OSMA and AMA.

ALLEN BEALE, MD, Sun City, Ariz.; Case Western Reserve University School of Medicine, 1928; age 82; died March 1, 1986; member OSMA and AMA.

THOMAS H. BREWER, MD, Columbus; Meharry Medical College, Nashville, Tenn., 1943; age 66; died March 17, 1986; member OSMA and AMA.

LOUIS W. CELLIO, MD, Columbus; St. Louis University School of Medicine, St. Louis, Mo., 1934; age 78; died March 23, 1986; member OSMA and AMA.

FLOYD W. CRAIG, MD, Coshocton; Ohio State University College of Medicine, 1930; age 79; died March 8, 1986; member OSMA and AMA.

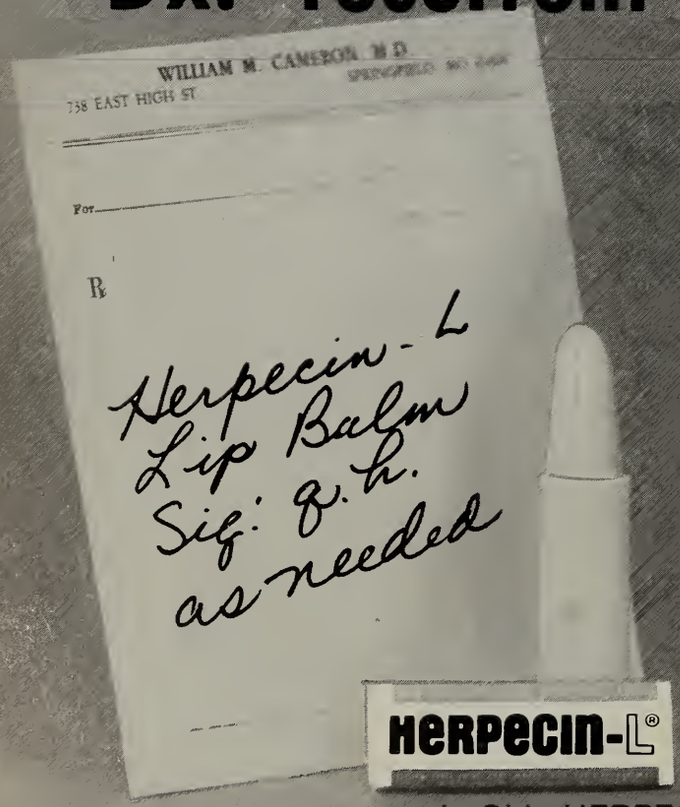
RALPH W. EDDY, MD, Cincinnati; University of Cincinnati College of Medicine, 1932; age 81; died March 24, 1986; member OSMA and AMA.

WILLIAM HARTLAGE, MD, Portsmouth; University of Cincinnati College of Medicine, 1934; age 80; died March 28, 1986; member OSMA and AMA.

NEIL D. MARTIN, MD, Dayton; Jefferson Medical College of Thomas Jefferson University, Philadelphia, Pa., 1956; age 55; died March 20, 1986; member OSMA and AMA.

V.F. PEKAREK, MD, Cleveland; St. Louis University School of Medicine, St. Louis, Mo., 1936; age 75; died March 23, 1986; member OSMA and AMA.

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M.A. SHILLING, MD, Mabank, Texas; University of Michigan Medical School, Ann Arbor, Mich., 1938; age 74; died March 29, 1986; member OSMA and AMA.

HAROLD SILBERMAN, MD, Cincinnati; University of Cincinnati College of Medicine, 1972; age 40; died March 17, 1986; member OSMA.

WILLIAM D. WELTON, MD, Dayton; University of Rochester School of Medicine, Rochester, N.Y., 1944; age 66; died March 20, 1986; member OSMA and AMA.

JAMES R. WILLIAMS, MD, Niles; St. Louis University School of Medicine, St. Louis, Mo., 1950; age 64; died March 18, 1986; member OSMA and AMA.

CARL J. WOLF, MD, Fremont; University of Cincinnati College of Medicine, 1938; age 79; died December 3, 1986; member OSMA and AMA.

WARD V.B. YOUNG, MD, Lorain; Case Western Reserve University School of Medicine, 1952; age 60; died April 1, 1986; member OSMA and AMA.

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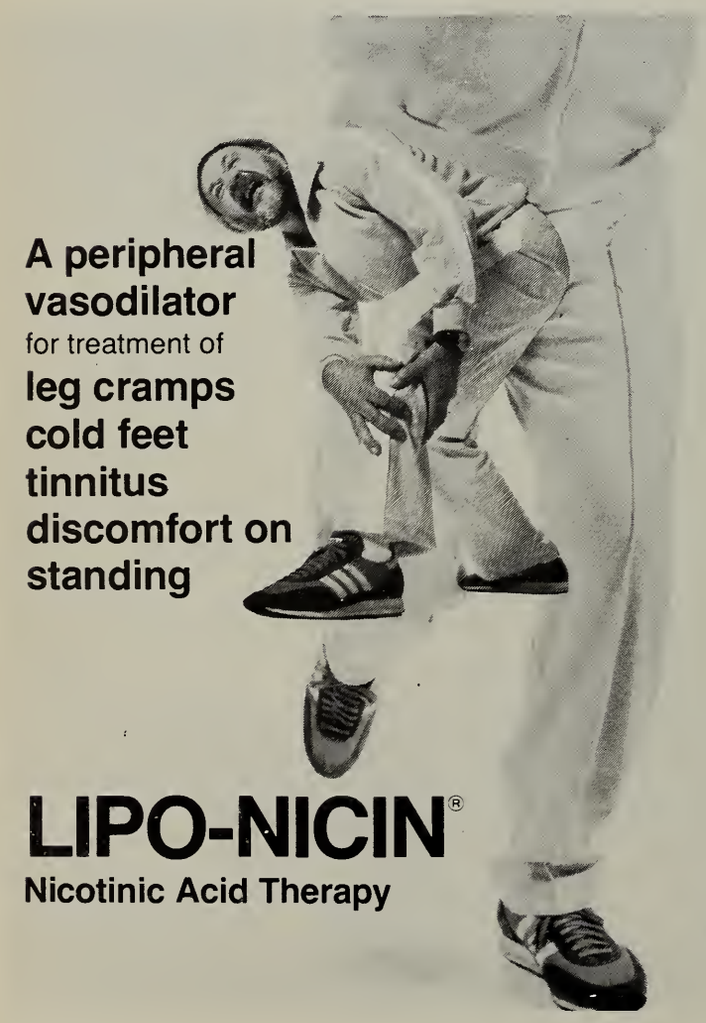
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Marje L. Persons
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Fernando O. Recio, North Olmsted
David E. Richter
Alan M. Rosenbaum
Sherri L. Routman
Stephen A. Rudolph, Shaker Heights
Carol A. Salewski, Independence
Michael S. Schneider
Martin A. Schreiber
James L. Sechler
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Robert L. Taber, Jr., Akron
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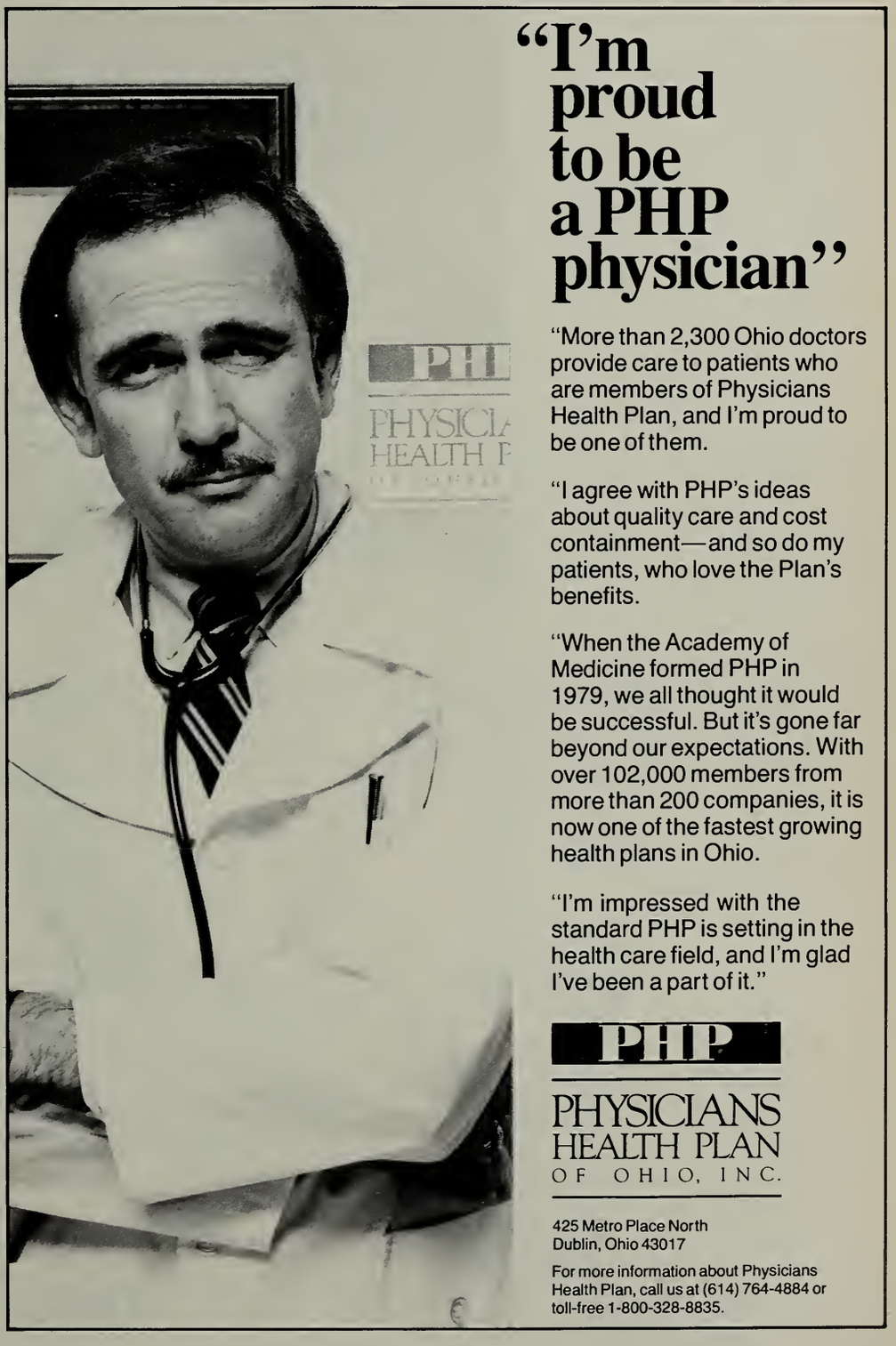
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Peggie A. Findlay
Oliver M. Fitzgerald
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continued on next page

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Shakuntala Bhagoji
David Brown
Theodore D. Fraker
John T. Kane, Perrysburg
Duane J. Kerscher, Maumee
William J. King, Sylvania
Roger R. Lenke
Alfredo O. Noriega, Oregon
Peter White
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Darice L. Zabak

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John Andrew Rogers, Jekyll Island

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Fayez Abboud
Scott Allan Gardner
Curtis R. Thompson
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STARK
James H. Arant, Canton
John D. Busowski, Canton
Warren Henry Kofol, Massillon

TRUMBULL
Peter Irace, Cleveland

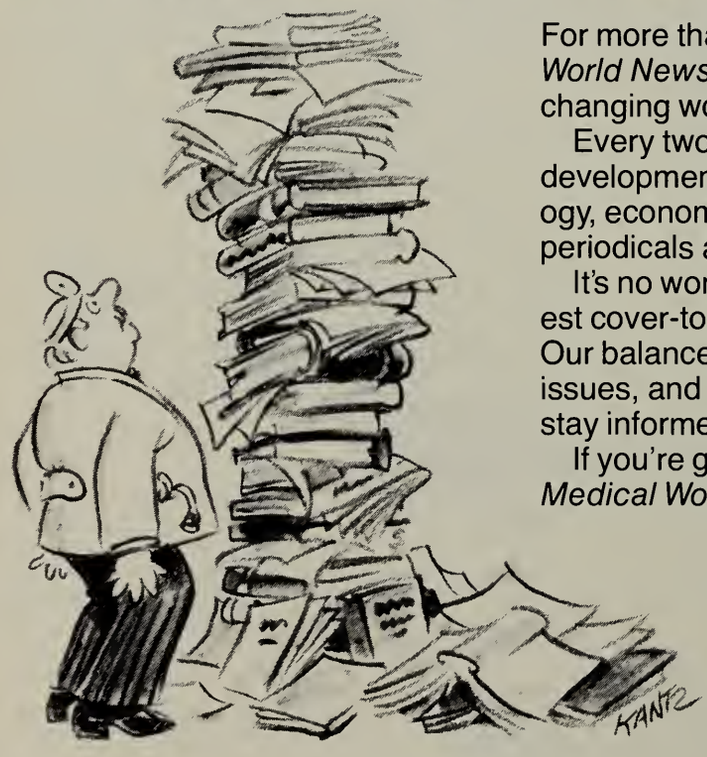
Colleagues in the News

NANCY H. BRIGHT, MD, a Steubenville pediatrician, has been elected president of the Ohio Valley Hospital Medical Staff.

JOHN CARPATHIOS, MD, FACS, a thoracic surgeon from Canton, has been elected president of the Massillon Community Hospital Staff for 1986. Dr. Carpathios is also a member of the OSMA Committee on Impaired Physicians.

MICHAEL J. GELFAND, MD, associate professor of radiology and assistant professor of pediatrics, has been appointed program chairman for the 1986 meeting of the Southeastern Chapter of the Society of Nuclear Medicine.

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Book Review

Mental Disability in America since World War II. *By Don Martindale and Edith Martindale; 294 pp; $15 (cloth); New York, NY, Philosophical Library, 1986.*

Don Martindale, PhD, is a retired professor of sociology. Edith Martindale is a registered nurse with a BS in sociology and is described as a psychiatric social worker. Together they have provided a philosophical sociopolitical interpretation of the history of deinstitutionalization of the mentally ill (including substance abusers and mentally retarded) in America.

After too much (and too little) of an introduction of the general history of psychiatry and some concepts of sociology, they describe how the problem of mental illness received very little attention until World War II. It was a problem for the individual states. State hospital systems had arisen and were progressing from being primarily custodial/warehousing institutions to becoming therapeutic communities. After World War II, especially with the increasing activity of the Veterans Administration and the National Institute of Mental Health, the problem was seen as national in scope. In the 1950s, "radical" psychiatrists (e.g., Szaz) and social scientists advanced notions that mental illness is a myth, that mental illness is a product of hospitalization, that hospitals are "snake pits" and are counterproductive. The concepts of the "right to treatment" and the "right to refuse treatment" had been developed in the courts. The Mental Health Centers Act of the 1960s created a set of "counter-institutions" to the state hospital programs. These were presented as effective and as cost-effective. All hospital care would be short-term, and all patients would receive inexpensive and adequate follow-up care in Community Mental Health Centers. The states, required to participate in cost sharing of the federal program, could not afford both that and their state hospital systems. California was the first state to force deinstitutionalization and quickly learned how only about half the patients received follow-up care and many of them became the "homeless mentally ill," existing in unsupervised and inadequate homes and hotels or even on the streets. As the state hospitals closed, it became extremely difficult for ex-patients to be readmitted. Instead of receiving better treatment, they often received no treatment at all. Death rates rose. New York did not learn from California; deinstitutionalization there had the same results. When the NIMH learned of these results, they stopped claiming credit for depopulating the state hospitals and gave credit to the neuroleptic drugs. The states saved money. Who profited? The "nursing home industry," the "halfway house industry," and psychiatrists. The mental health centers have devoted their resources to the practice of "middle class psychiatry," and "only sporadically do they offer services to the seriously mentally ill." (p. 265)

There is no end to the story. This is where we are now. But why did it happen? The authors interpret that the crusaders were not actually interested in the care of the mentally ill, and that this is manifested in the "ideological character of their language" rather than in objective language. "The crusader was operating with a worst-case scenario of what could happen to himself. In his stereotype of the mental patient, the crusader — though he seems not to have recognized this — was looking at himself." (p. 268)

My first impressions of this book were that it was not worth reading to completion. It was redundant, seemed to have no theme relevant to the title, had nothing about psychiatry or psychiatric treatment or research or clinical developments in psychiatry. It had nothing about historical figures in psychiatry or psychology during this time frame. There was a great deal of subjective bias. The authors had addressed only a narrow segment of the problem. They spent too much time and space on book reviews. There are typing, printing, and grammatical errors. There was much with which I disagreed. But my first impression was wrong. The book *must* be read to completion. The last two chapters are definitely worth reading, whether or not one agrees with them. The last chapter itself is a nice summary of a provocative interpretation.

This is not an authoritative or well-researched book, yet it contains interesting sociopolitical philosophy. It can be used, but not alone, as a reference book. It deserves to be in public libraries of all types. It is particularly relevant to undergraduate sociology students, sociologists, newspaper writers, and above all for politicians . . . who won't read it. And we may all suffer for that.

— *James R. Hodge, MD*
Professor and Chairman
Department of Psychiatry
Northeastern Ohio Universities
College of Medicine

Why join organized medicine?

By Katherine E. Wisse

Physician nonmembers may ask you why you belong to medical societies and why it is important for all physicians to belong. You might find this a difficult question to answer.

Membership in a county medical society is important because it assures participation with your peers in the medical affairs of your community. Many counties publish bulletins with medical news of local interest. Interchange of ideas with your colleagues and referrals are expedited. Your county society membership lends credibility to your standing in the community.

Membership in the Ohio State Medical Association is important because your support helps to strengthen OSMA's representation when it speaks to the legislature on such issues as medical professional liability, allied health practitioners, medical practice, medical ethics, the state medical board and other medically related topics. An important benefit of membership is your subscription to

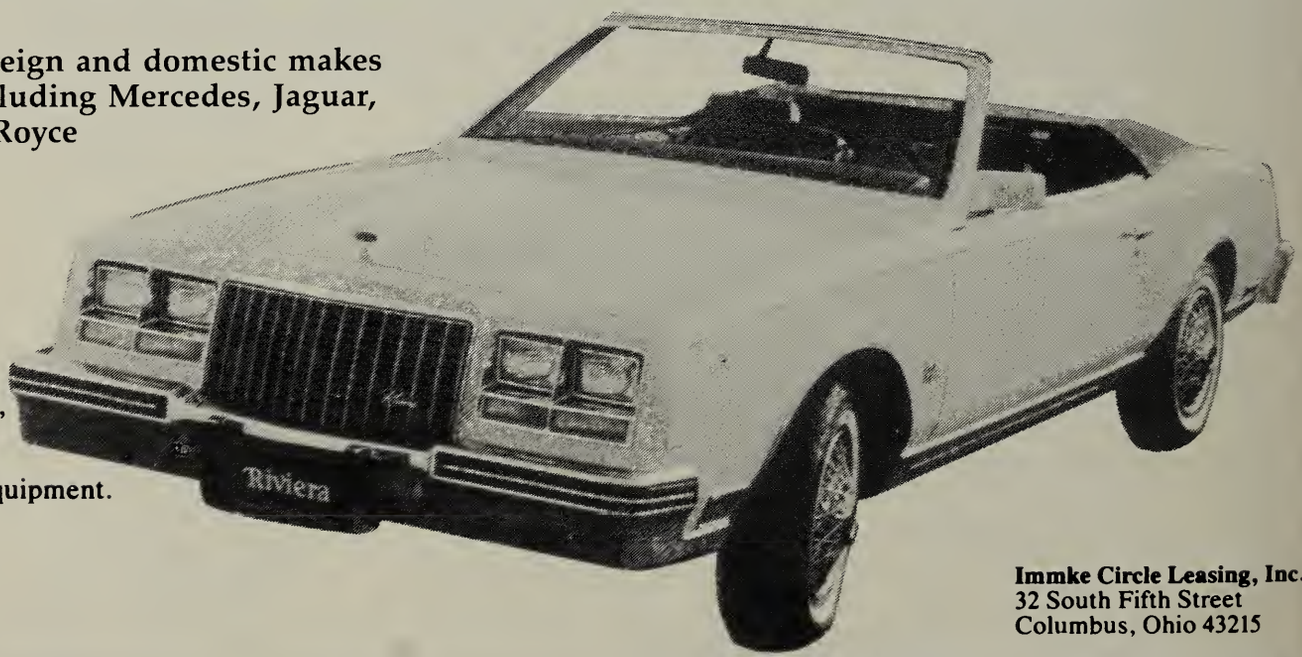
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Membership in organized medicine, which would include all of the above organizations, benefits the entire profession. Increased competition and changing health care delivery patterns are just two of the common interests that bond these organizations together.

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Katherine E. Wisse is the Director of the OSMA's Department of Membership.

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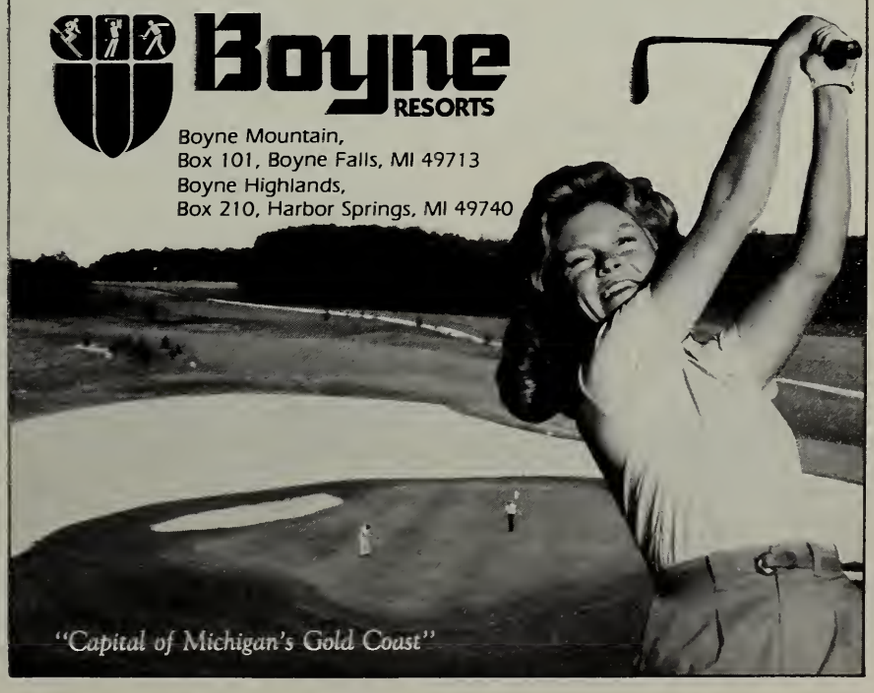


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EMERGENCY PHYSICIAN — Eastern Ohio community hospital with 10,000 annual ER visits has full and part-time staff position vacancies. One hour from Pittsburgh, two hours from Columbus. Independent contractor status with paid malpractice. Low volume permits 24 hour shifts, 120/hours/2 weeks. Annual full-time income of $140K possible. Positions available July 1. Send CV to Lawrence England, City Hospital, Bellaire, Ohio 43906/(614) 671-1200.

FAMILY PRACTITIONERS — Board eligible/certified family practitioners to associate with board certified general surgeon. Guarantee: competitive salary, benefits, coverage, full privileges. 24 hour emergency room coverage. Contact: Village Medical Clinic, 1814 Enslee Road, Coshocton, OH 43812. Phone: 614-622-7497 after 7:00 p.m.

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MD, MEDNET/Euclid Clinic Foundation, 18599 Lake Shore Blvd., Euclid, OH 44119.

MARIETTA, OHIO: Emergency department directorship and staff position available at 200-bed facility. Board certification or board eligibility in emergency medicine or primary specialty preferred. Contact: Emergency Consultants, Inc., 2240 S. Airport Road, Room 26, Traverse City, MI 49684; or call 1-800-253-1795, in Michigan 1-800-632-3496.

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OB-GYN: 2 person OB-GYN group seeks a third BC/BE OB-GYN, preferably a female. Guarantee: competitive salary, benefits, with third day coverage, etc. Send CVs to Box No. 89, c/o Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

OHIO: Career-oriented emergency physician needed for full-time emergency position in a modern community hospital in Northwest Ohio. Moderate volume, competitive salary, malpractice insurance and flexible schedule. Position available immediately. Send resume to P.O. Box 85, c/o Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

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OTOLARYNGOLOGIST: ATHENS, OHIO — Immediate practice opportunity available for board certified/eligible otolaryngologist in progressive, academic community. The hospital is fully accredited and equipped to accommodate a qualified otolaryngologist. The Athens community offers excellent school systems and outdoor activity. Primary service area includes population of 60,000. Please submit resume to Philip D. Kinnard, MD, Chief of Surgery, O'Bleness Memorial Hospital, Hospital Drive, Athens, OH 45701.

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EQUIPMENT WANTED

Used Xerox Copy Machine, Model #3107 or 3109, LDC. Reply to Box #87, c/o Ohio State Medical Journal, 600 S. High St., Columbus, Ohio 43215.

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Health Care Personnel Consulting
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215-667-8630

PRACTICE FOR SALE: I am retiring from general practice and would like a general or family practitioner to take over my practice. Northern Ohio on Lake Erie. Replies to Box No. 88, c/o Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

PRACTICE FOR SALE: Busy invasive and noninvasive cardiology. East Cleveland area. Send CV to: P.O. Box 86, c/o Ohio State Medical Journal, 600 South High Street, Columbus, OH 43215.

OHIO — LAKE ERIE SHORES — SANDUSKY

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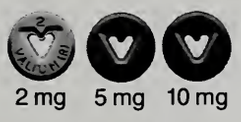
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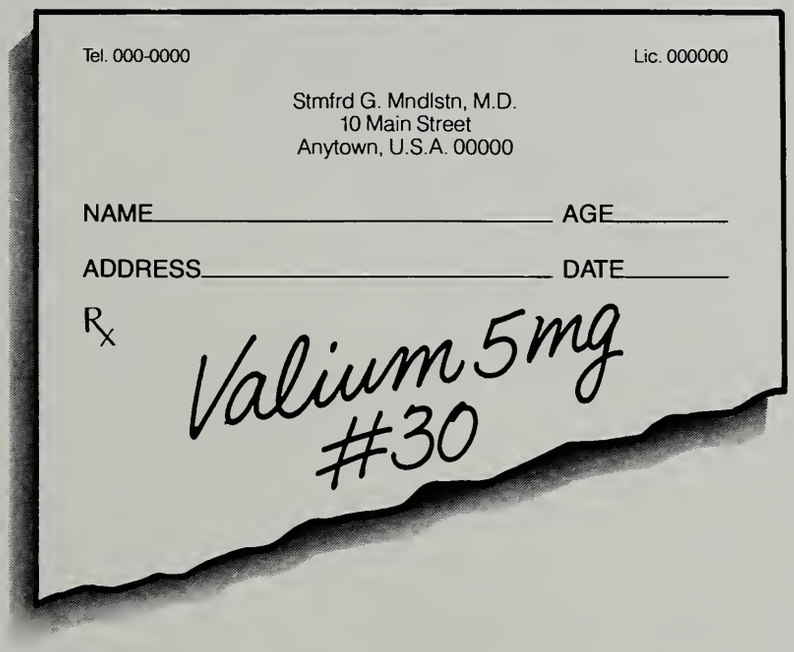
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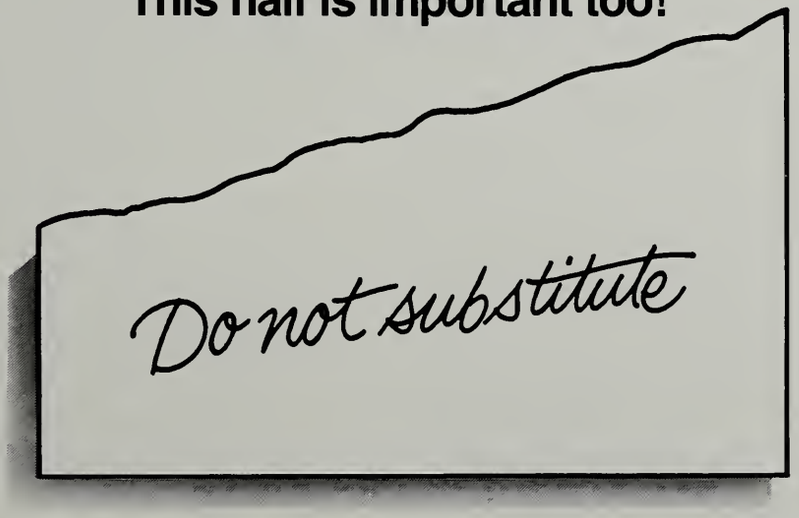
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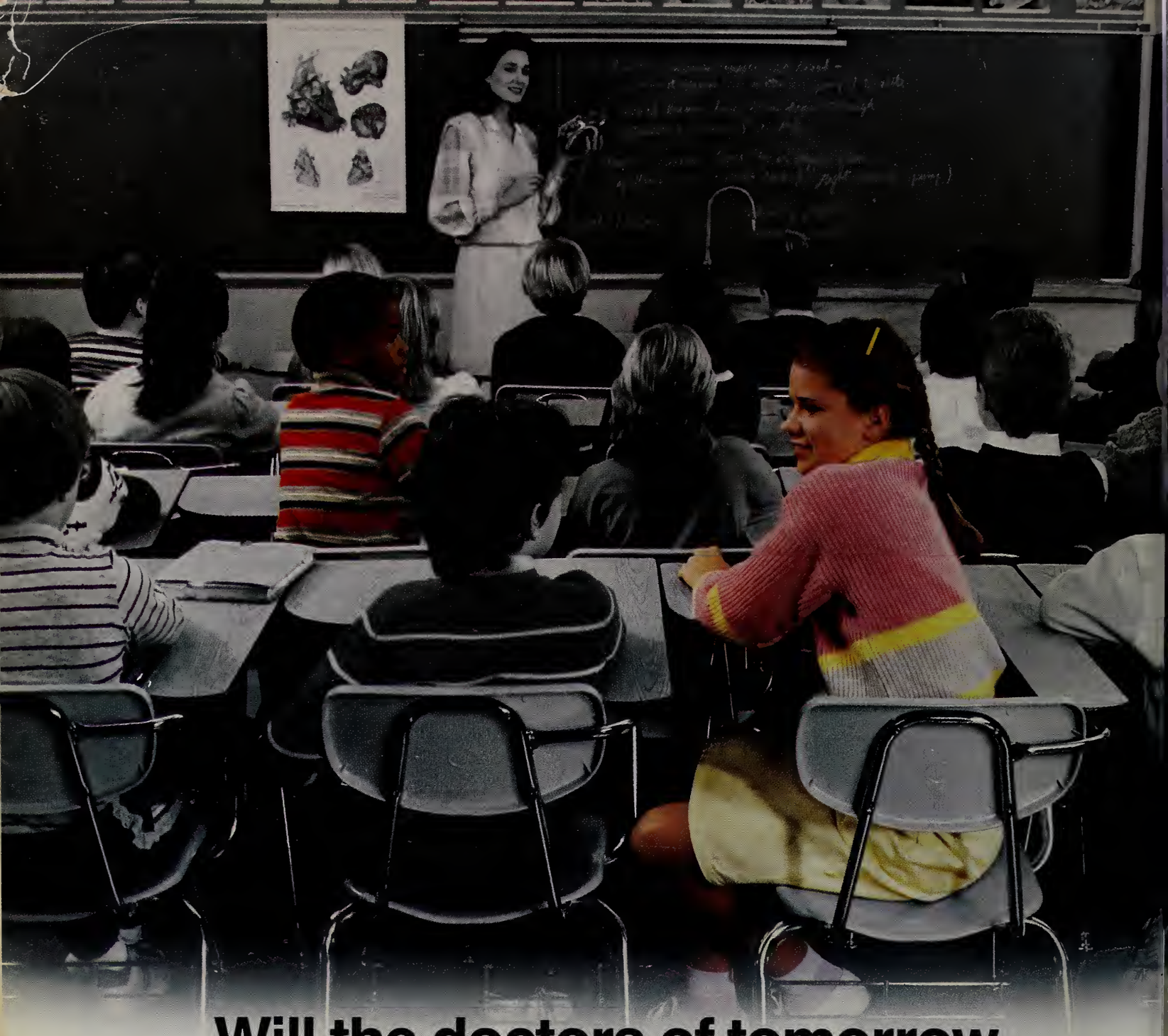


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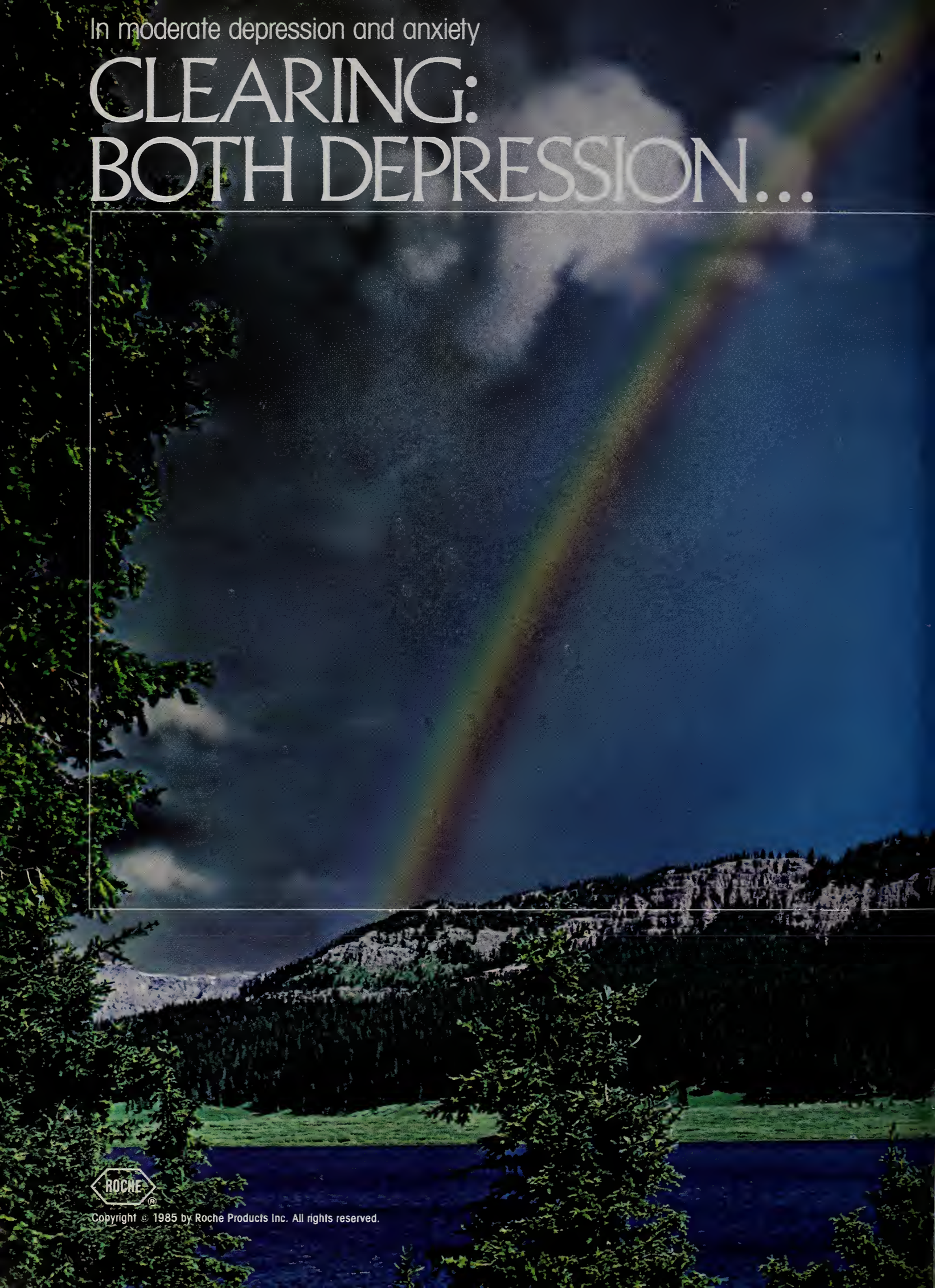
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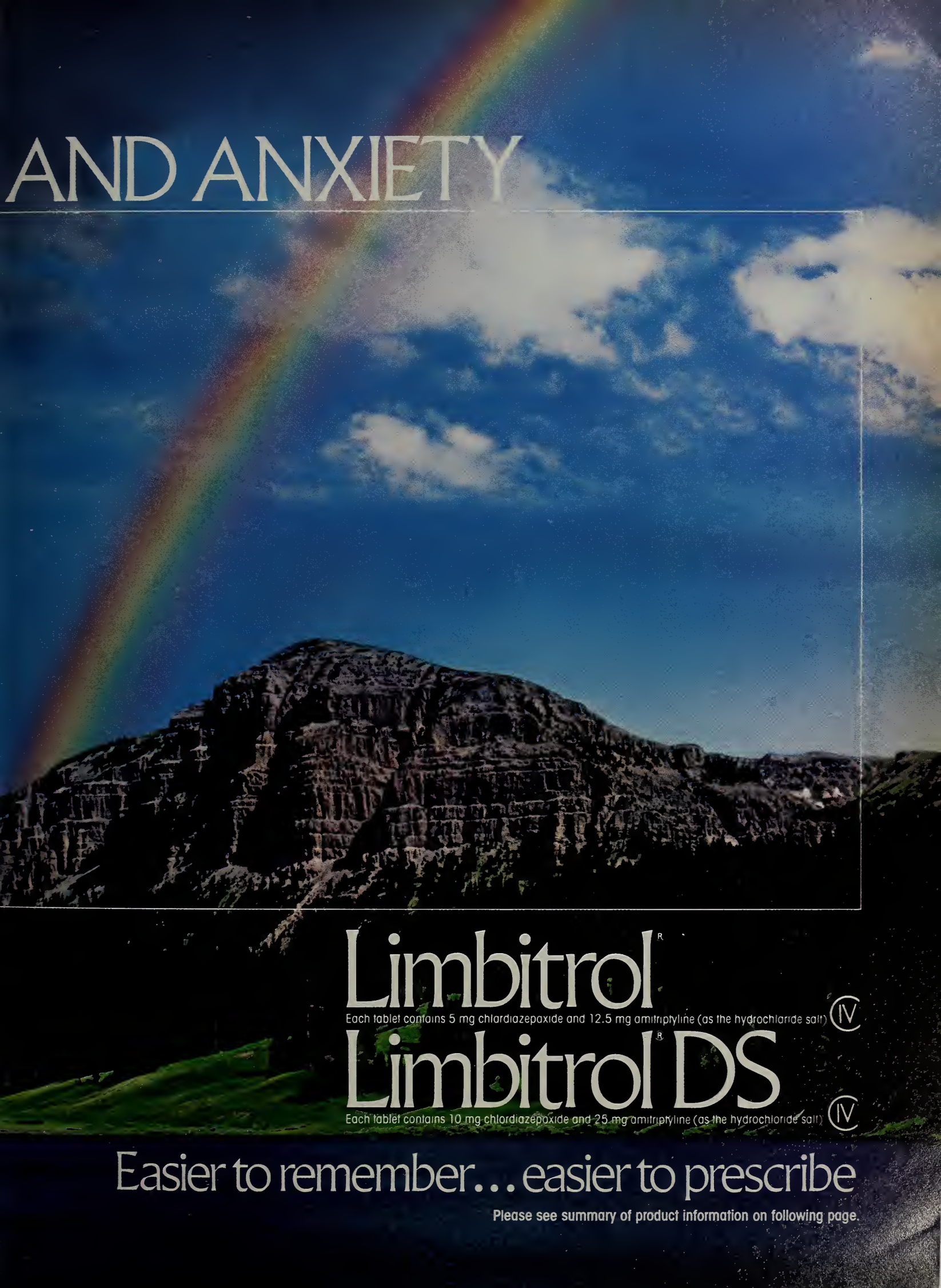
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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiavascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neuralogic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Antichalinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematalagic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastraintestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.
Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: *Double strength (DS) Tablets*, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets*, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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Presidential Perspectives



John E. Albers, MD

Becoming President of our organization is a very distinct honor and privilege for me and over the ensuing year I will do my utmost to fulfill this position by giving it the time and energy required.

Our organization is strong, forceful and innovative. With the challenges that confront us now and that are coming in the future, I know that the leadership, along with our dedicated staff, will live up to those challenges, and perhaps present a few challenges of our own.

This issue highlights the annual meeting that was held in May at the Dayton Convention Center. I hope that each of you takes the time to read portions of the meeting report elsewhere in this issue. I believe through your attention to this you will better understand the work of our organization and its viability. The Ohio State Medical Association has two purposes in mind. It has been formed for the protection of our patients' rights and for the protection of the physician as well, along with the education of both groups. There is no way to be better represented and to present a unified voice than through your state organization and through the national organization, the American Medical Association.

If we look at just one area in which our state organization has excelled, it is in the field of legislation. Not only have we sponsored new legislation and introduced several, but we have also been a watchdog over numerous legislative items which have been presented in the state legislature that affect all of us in medicine. The very history of our organization shows that we have been effective in this field. Out of our recent state meeting, we are carrying eleven resolutions to the American Medical Association — resolutions which originated from individuals in Ohio's counties and county medical societies, were passed by our House of Delegates and are now being sent on to the American Medical Association where your delegates will do their best to have the resolutions passed by the AMA House.

Belonging is important. An organization such as ours cannot thrive without membership, nor can it thrive without the interest of its members. Involvement in the state organization and in the national organization is extremely important. If medicine is to accomplish what it would hope to accomplish, it needs to be unified and to speak with a unified voice. Too often we have been divided in opinions, having large groups of physicians giving one point of view and another larger group giving an opposite point of view in their testimony before committees. This diversification of opinion only weakens medicine's voice. Committee members hearing such diversification say, "How can we give them what they want, when they can't agree on what they want themselves!" There are many groups seeking to speak out for the physician — specialty groups, HMOs, PPOs, hospitals — all of which have some self-interest. Although they may be very honorable, they do not speak for all physicians. The thoughts generated from such groups become self-serving and a projection of small segments of our profession. It is only through the unified efforts of an organization such as ours that all physicians can be heard.

It has always been my belief that you are physician first, a specialist or member of another group second, and whatever is good for all physicians will also ultimately be good for me as a specialist or member of another group.

We, as physicians, share a great profession — a profession which is limited by its very nature to only a few fortunate individuals. Our profession has been tarnished in the past and we have survived. Our profession is being attacked on all fronts today and we will survive. But in surviving, we all individually should take a look at what we do each day — how involved we are in our patients' care, how sincere we are in our patients' care — and realize that our sole purpose in being a physician is to render quality health care. Often, from a non-physician viewpoint, it appears that the primary purpose may be monetary, and we need to examine ourselves to see where we may have contributed to that viewpoint; our style of living, our charges, our interest in financial matters and our apparent lack of concern for the patient's needs and wants.

We are not a perfect profession, but we are an ideal profession. As long as we maintain our ideals and our principles and continue to work within the framework of organized medicine, we will maintain ourselves as a highly respected profession.

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Ohio State Medical Journal Manuscript Guidelines

1. EXCLUSIVE PUBLICATION. Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. CORRESPONDENCE. Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. MANUSCRIPTS. (a). Manuscripts should be submitted *in the original* on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). *The entire text including lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.*

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. ILLUSTRATIONS. (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. *The Journal* will assume $10 of this expense and the author will be billed by *The Journal* for the remainder.

(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

(c). Legends for the figures should be written on separate paper.

(d). The author must affirm that he has *written releases* on all photographs in which patients can be identified.

5. ABSTRACTS. A *short* (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. SUMMARIES. The summary should be a concise restatement of the information given in the body of the article.

7. REFERENCES. (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the *order of their appearance in the text.*

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

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The Business of Annual Meeting

This year's Annual Meeting coverage is a little different . . . fewer pictures, more copy.

The reason?

To bring you more of the story, of course. Please don't get us wrong. The pictures are a necessary part of our coverage and provide a valuable record-keeping function of this association, but, generally, pictures reveal only *one* side of the meeting — the pomp and circumstance of the occasion — and not the nitty-gritty discussion and debate on issues which have been considered so important and so timely that they have been brought, by way of written resolution, to the attention of the membership at large.

The resolutions submitted and considered by the House each year *are* important to medicine — and to you — because they cut through the thousands of health-care issues that are raised annually and seize those which are — or should be — of the greatest concern to you, the practicing physician.

So, this year, our Annual Meeting coverage *does* look a little different. The pictures are still there (maybe not as numerous), but, *in addition,* you'll now find a brief report which highlights the *business* meeting of this year's House. In no way do we intend for our report to be a substitution for the official Minutes, which will appear in another issue. Our review is simply to provide the number of you who are unable to attend an Annual Meeting with a bit more flavor of the function, as well as, perhaps, a better-rounded view of what these meetings are all about. We hope you approve.

Also in this issue, you'll find some good stories that came out of the Annual Meeting . . . the discussion on health-care costs, led by OMPAC speaker Uwe Reinhardt, for example. More stories will follow in other issues.

And our "mixed bag" contents continue to grow. Thanks to I.C. Sharon, MD, who submitted his article on psychological management of patients by the non-psychiatrist. It may very well provide you with some new insight on how to handle those patients in your practice who are in some emotional turmoil. And a special thanks to Jack Sullivan, MD, of South Charleston, Ohio, who sent us an essay written by one of his patients, entitled "What Is a Doctor?" We think you'll find the piece as warm and witty as we did.

Our "Clinical Update" section continues with an article by Helmut Schreiber, MD, one of the pioneers in the "gastric bubble" therapy developed for the clinically obese. His article answers all the questions you — and your patient — may have on the subject.

Finally, don't miss this month's financial column — it's full of sound advice.

Next month, the *Journal* will take a look at the new specialty of addictionology, as well as at the new developments that are rapidly occurring in this field. We hope you'll watch for it. — *Karen S. Edwards*



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Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
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Pediatric Use: Safety and effectiveness in children have not been established.
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February, 1985

Letters to the Editor

Liability pitfalls

To the Editor:

The survey recently mailed to OSMA membership has worthy goals. Hopefully they will be attained, but there are pitfalls that should be avoided.

The media can and will twist quotations and there will be no sympathy from the average patient. Insurance companies have mandated a coverage of $1 MILLION for each staff member. This can only increase the cost of medical care. Selected hospitals demanded a total of $300,000 a few years ago. Today $1 million, tomorrow $2 million?

Asking the legislature for help can be more dangerous. Remember the last fiasco? Medical license fees skyrocketed, competent physicians were forced out or retired prematurely. The $200 piggyback increase was added to the already excessive malpractice premiums. Some of this was returned, but it should never have been paid in the first place. OSMA could not or did not influence the Medical Board to accept OAFP credit hours, which are higher in quality and preceded state mandated CME by years.

Our nation cannot remain free and eliminate the right to sue for justice. By the same logic our nation cannot remain free when an insurance company can dictate to a physician the X number of dollars one must carry to practice medicine.

A cesspool of paganism controls our nation. The idols worshipped daily are three: 1) Scientific Knowledge; 2) Technology; and 3) The American Way of Life (Love of MONEY). Biblical guidelines warn against idol worship. We should be content with what we have. The more one has the more one wants. No one can really do anything against God, and any evil done against those who trust God will be turned for their own good. Scriptures for these ideas are found in Hebrews 13:5-6 or Psalms 103:1-5.

It will not be easy but the patient must be FIRST and money SECOND. Then and only then will the standing of the medical profession be elevated back to its rightful position. The present state of litigation is a cancer that will destroy medical care that has been second to none. It is either SACRIFICE for change or surrender basic freedoms.

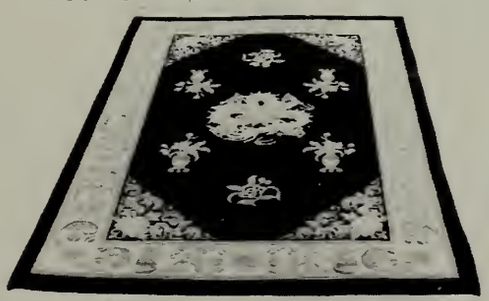
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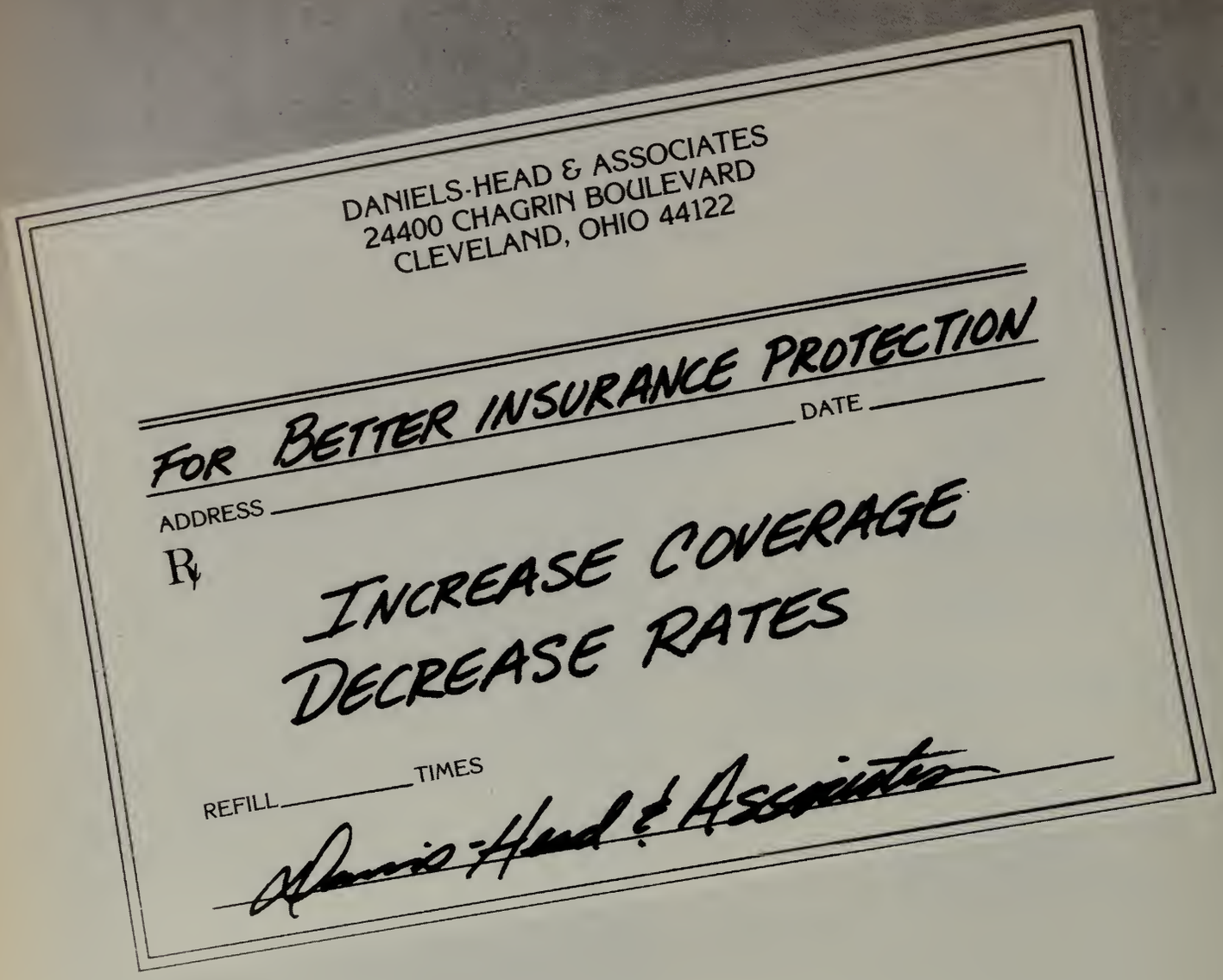
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Second Opinion

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of the Ohio State Medical Journal or the Ohio State Medical Association.

Telephone Answering Service — You Can't Afford Anything Less Than the Best

By Robert D. Gillette, MD

The sound of the telephone bell jarred me from sleep. I snapped on the light and reached for the handset. "This is the answering service. PleasecallOscarBronfman at sixseventwofourfiveonesix."

"Um, yeah." Still not fully awake, I fumbled for my glasses, picked up the pen that had just fallen to the floor, and made a note on the scratch pad. "Seven, six, two — what was the rest of it?"

"That's *six, seven,* two, Doctor, then four, five, one, six." There was a note of impatience in her voice, perhaps even condescension. She didn't seem to realize that a person being aroused from sleep for an important message may need a few seconds to wake up before being able to think clearly. Or maybe she did know but was so busy that she had run out of patience.

I wrote the name and number down and read them back. This time I had them right. After calling the patient and dealing with his problem I snapped off the light and lay down, but thinking about the operator and her impatience kept me from falling asleep. She could have given me time to wake up before firing off her message, I thought. Better yet — but I'll come back to that.

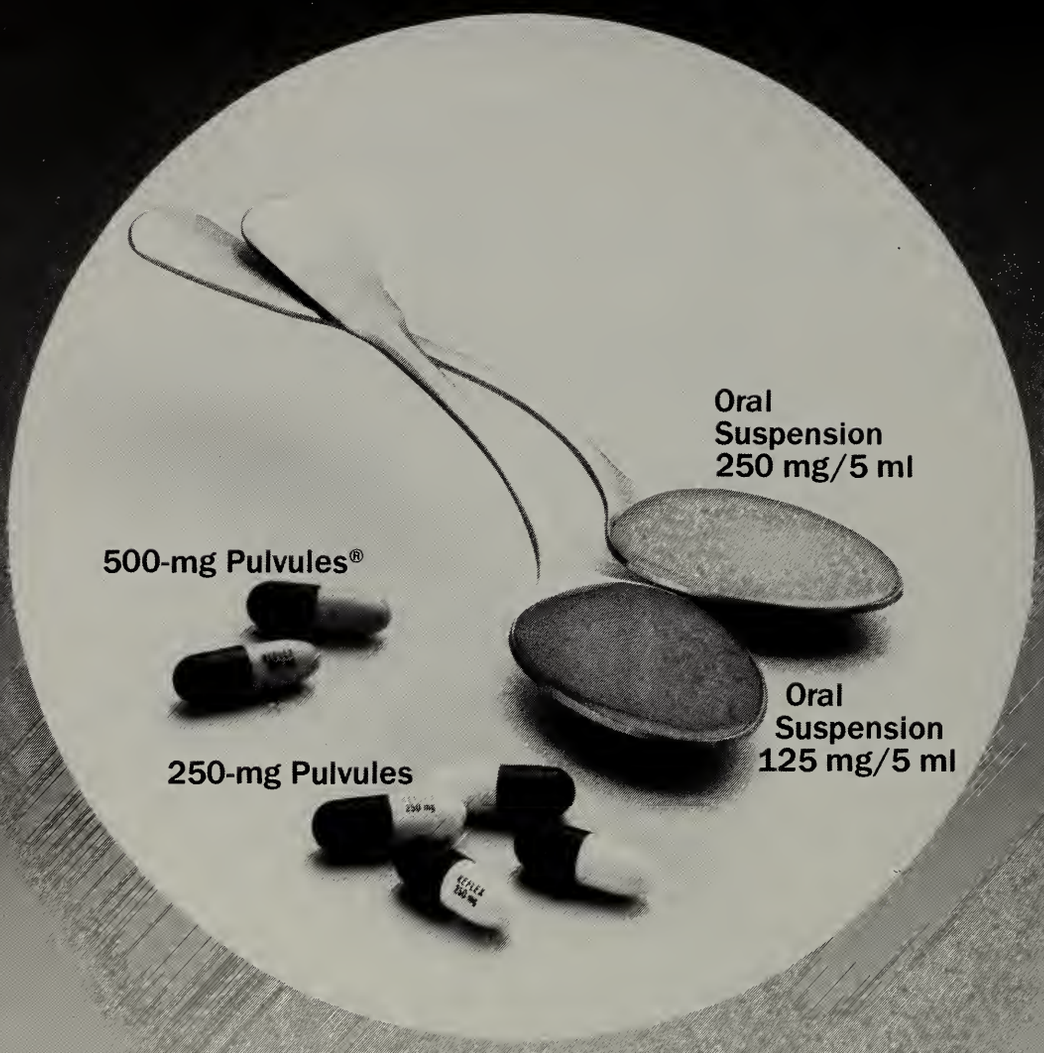
Complaints about answering services are a dime a dozen these days: Rudeness, errors in noting and reporting telephone numbers, misunderstandings about on-call arrangements, long waits on "hold," and a dozen minor irritations. Sometimes it seems as though there are just two kinds of operators: Those who just started last week and haven't had time to learn the job, and those who started thirty years ago and have forgotten how to be pleasant or considerate.

The blame doesn't lie entirely with the operators, of course. Some doctors, perhaps reacting to the pressures of their practices, tend at times to take their frustrations out on the answering service people. Some aren't always clear and consistent in their requests for service, and some make unreasonable demands. A few are slow responding to their pages; this can put an operator in a very uncomfortable position if a worried patient keeps calling back to ask why the doctor hasn't responded.

Physicians need to let their answering services know what specific services they expect. Do you want to be contacted right away when a patient calls, or would you prefer that they wait until a few messages have accumulated? Should they ask the caller about the nature of the problem, or would you rather get that information yourself? Do you use your pager at all times, or would you prefer to be contacted by telephone when you're at home? What should the operator do if you can't be reached in a reasonable length of time?

If a mixup does occur, don't be too quick to blame it on the answering service. Patients occasionally bend the truth when they haven't followed instructions correctly. Doctors have been known to fall back asleep without taking care of incoming messages.

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Second Opinion

continued

Instructions transmitted by medical office staffs can become garbled. It may be best to overlook an occasional error. If a pattern appears, though, you'll want to gather all the facts, let the service know what has transpired, and see that it doesn't happen again. If it does, you may want to start looking for another answering service.

Maybe I'm just spoiled. Two decades ago, while practicing in a rural community, I signed up with a small answering service in the county seat. The operation was friendly, mature and personalized. The staff knew each doctor's preferences: If you wanted them to ask why a patient was calling or not, whether you wanted non-emergency calls held while you were in church, and the like. If they called you during the night they'd wait a few seconds for you to wake up before giving you any information. Most of the time they'd keep the patient on hold while they dialed you, and then "patch" the lines so you didn't have to dial the number yourself. This was a convenience for the practitioner, and patients liked being able to talk to their physicians with only a few seconds delay. Patients had other reasons to like the service. There were enough lines and operators that being put on hold was seldom a problem. The staff always managed to be pleasant and to present a caring image, even when dealing with anxious or impatient callers.

There's no reason why a company couldn't provide that level of service today. It would cost more to hire and retain skilled operators who take pride in their work and can deal effectively with anxious patients and grumpy doctors. There would be extra expense in staffing the switchboards heavily enough so the operators would seldom be forced to hurry. But telephone answering service is a small item in the total overhead of a medical practice, so in the long run a top quality, premium price answering service would be a bargain. The added cost would be repaid quickly through better relations with patients. Your answering service represents an important part of your public image. It may be the first contact potential patients have with your practice, and it's the one established patients are most likely to have when they face an important (to them) medical emergency.

A tactful, resourceful answering service operator who's "on your side" can be valuable at times when there's a mixup in your practice, such as a misunderstanding regarding coverage arrangements or an unavoidable delay in answering your pager. These things happen in the best of practices. Patients will usually overlook them if they think the people involved were honestly trying to do their best. They are less likely to be tolerant, though, if they must communicate through an operator who seems to be incompetent or uncaring.

If you have a good service, by all means support it. Let the operators know you appreciate their good work, and send them a remembrance at holiday time. A first rate answering service is worth every penny you pay for it, and more. **OSMA**

Robert D. Gillette, MD, an Associate Professor in the Department of Family Medicine at the University of Cincinnati, formerly practiced in Huron, Ohio.

JCAH to develop home care standards

The Joint Commission on Accreditation of Hospitals has initiated a project to develop comprehensive standards and a survey process for community-based and hospital-based home care programs. These will be the first comprehensive standards developed for both kinds of home care programs, according to Barbara McCann, who is directing the Home Care Development Project.

"The home care industry is in a period of tremendous growth, diversification and expansion, as business and government look for ways to decrease inpatient stays," said McCann, who is also Director of the Hospice Accreditation Program. "This growth causes a need for comprehensive standards. The Joint Commission standards will address four major areas of home care."

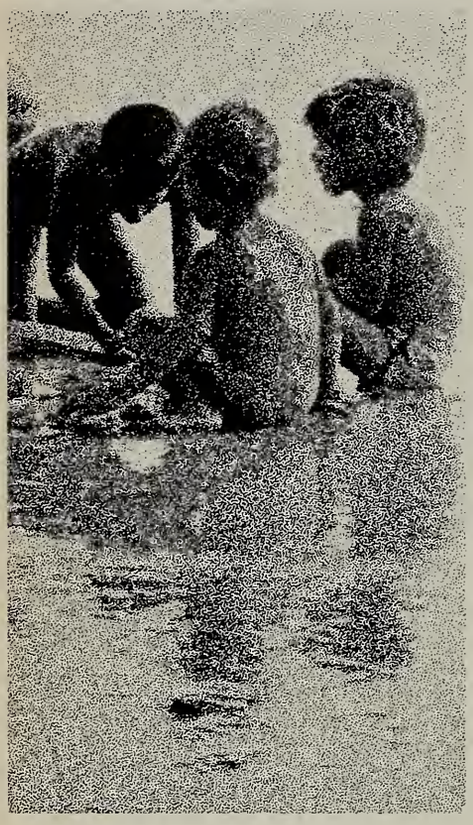
These areas include:

- The traditional Medicare home health agency,
- Homemaker and home health aide services,
- Home infusion and other high technology services, and
- Durable medical equipment.

The project was approved at the December meeting of the Joint Commission Board of Commissioners.

News Digest

Edited by Deborah Athy



Skin smart

The lifetime incidence of skin cancer could be reduced by 78 percent if individuals would use sunscreen until age 18, according to a recent report in the *Archives of Dermatology.*

"Pediatricians should encourage sunscreen use and sun avoidance as a regular part of pediatric preventive health care," the report says.

By using a sunscreen factor of about 15, benefits to be reaped include reduced risk of melanoma and of basal and squamous carcinomas of the skin — not to mention reduced risk of sunburn and slower aging of the skin.

New device buttons up medical procedures

The FDA has just granted its approval of a thimble-sized device, known as the "skin button."

The button, made of Tecoflex, a special plastic material into which skin cells grow (providing an impervious barrier against bacteria), can be implanted almost anywhere in the body, providing a permanent "window" to the outside world. In fact, once the button is in place, such procedures as dialysis, drug delivery, chronic feeding and energy transmission for artificial hearts will be made much easier — not only for the physician, but for the patient.

The button is the brain-child of Benedict Daly, MD, of the New England Center Hospital in Boston.

"Remembering when" can be healthy

Don't worry about those elderly patients who come into your office and spend more time relating to you some by-gone reminiscence than running down the symptoms that brought them there in the first place.

According to an article that ran in the publication *Medical Aspects of Human Sexuality,* reminiscing patients are probably healthier, and more mentally-adjusted than their counterparts who do no reminiscing at all.

"Memory is a vital function in *all* organisms, an integral part of the ability to adapt and survive," says Robert Kastenbaum, professor of gerontology and director of the Adult Development and Aging Program, Arizona State University, in the article.

As we age, the struggle to relate the past to the present may become more difficult. The working memory begins to falter, and reminiscence becomes easier. This "living in the past" is most useful to long-institutionalized nursing home residents, who may find more comfort, love and satisfaction in the reminiscence than they are feeling in the situation they currently find themselves. This type of behavior is not unusual to either young or old adults when the present seems dreary or oppressive, says Kastenbaum. Other elderly persons use reminiscence in a resourceful and problem-solving manner to plan their future and to maintain a vigorous inner life.

"To despise reminiscence as a form of regression and aging is to deprive ourselves of a distinctly human attribute: the ability to relive and reshape our lives by interacting with the selves we have been."

a compilation of the latest developments, reports and products of interest to physicians.

Insulin in pill form

For years scientists have been seeking an alternative to insulin shots for diabetics — and now it appears those years of research have paid off.

Scientists at Bowling Green State University and the Medical College of Ohio are waiting for government approval on a plastic pill coating that could make insulin in a pill a possibility.

In the past, insulin has been ineffective when taken orally because it is broken down by enzymes before it reaches the large intestines. The coating, therefore, would protect the insulin until it reaches its destination.

The approval of this type of pill coating would also make it possible for some types of pain killers and vaccines to be given orally.

Psychological health in children

Pediatricians, family practitioners and other primary care physicians who treat children frequently can aid in the effort to spot psychological problems early, according to one child psychiatrist.

Michael Jellinek, MD, assistant professor of psychiatry at Harvard Medical School, suggests that during a regular checkup, physicians ask children a couple of age-relevant questions about each developmental area in order to detect potential problems.

These questions center on five functional areas of a child's life — school, play, friends, family and general mood. Dr. Jellinek, who also is the chief of child psychiatry at Massachusetts General Hospital in Boston, currently is developing a screening questionnaire which could be used by the physician during the child's annual physical.

In younger children, parents would answer the questions about their child's functioning, while in older children and adolescents, the child could answer the questions.

According to Dr. Jellinek, between 30% and 50% of pediatric office visits can concern psychosocial or developmental issues. Due to the high divorce rate in this country and other childhood stresses, psychological problems are more prominent in children today, he adds.

Because parents often are too close to the problem, they may not be able to detect these problems in their children. However, the physician is in a key position to help identify those children at risk who might later develop more serious problems such as suicidal tendencies and drug or alcohol abuse problems.



Team physicians recommend mandatory drug testing

Ohio physician John Bergfield, MD, was one of three professional team physicians who called for mandatory testing of drug abuse for college and professional athletes at a recent meeting of the American Academy of Orthopedic Surgeons.

Dr. Bergfield, team physician for the Cleveland Browns and Cleveland Cavaliers and consulting physician for the Cleveland Indians, said, "We're not going to eliminate drugs in sports — any more than we're going to eliminate drugs in society — but we have some excellent programs in place. The team doctors are sharing their knowledge, and the players are getting the benefit of an enlightened program that is meant to help them."

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Ohio medi-scene

Health care in a buyer's market . . . You are what you eat — maybe . . . Toledo student takes OSMA Science Award . . .

Delivering Health Care in a Buyer's Market

The US health care budget will continue to rise through the 1990s and physician incomes will remain intact, predicts Uwe Reinhardt, PhD, a noted lecturer, health care economist and professor of political economy at Princeton University.

However, the health care delivery system in this country will undergo even more changes, and while maintaining economic freedom, physicians will gradually lose their clinical freedom as third-party payors have a greater and greater say in when and how care is delivered.

Reinhardt, who was the featured speaker at the OMPAC, Ohio Medical Political Action Committee, luncheon held May 3 as part of the OSMA 1986 annual meeting, said in an interview prior to his address, "Some people have argued that health care costs will be down to 9% of the GNP (Gross National Product) by 1990. But I don't believe it for a minute."

One reason the economist sees no break in the upward trend is that "the (health care) product continues to develop. Today we can't even scratch the surface of what will be available in the future through bioengineering, microbiology. These products will be expensive — but we will still want to buy them."

Another factor, he adds, is the definition of health care. "Does health care include items like lifestyle management and cosmetic surgery?" If so, says Reinhardt, as the baby boom generation demands more and more of these services, a greater and greater share of the health care dollar will shift to these types of expenditures.

But health care costs cannot continue to rise at 14% a year, while the GNP increases by only 9%, Reinhardt told the OMPAC audience. "By the year 2000, 21% of the GNP — or every fifth dollar — will go to health care," if this trend continues, he says. And, eventually, the entire GNP would be eaten up by health care costs.

So how will Americans afford health care in the future? "We need to get off the kick of a one-tiered health care system," Reinhardt says. "It's a pipe dream



Economist Uwe Reinhardt discusses the health care marketplace during the OMPAC Luncheon, held during the OSMA's 1986 Annual Meeting.

Ohio medi-scene . . . continued

Delivering health care . . . *continued*

we could never afford to begin with." Today, he continues, America has the most expensive health care system in the world — representing 11% of the GNP — because it offers "perfect egalitarian access to health care, totally independent of a person's ability to pay for it."

Through social programs such as Medicare and Medicaid, the government has traditionally given even the poor and elderly access to the highest quality of care available, and, until recently, it reimbursed physicians and hospitals in full for the care they delivered. "We gave you the key to the treasury," Reinhardt says. "No resources were reserved. When someone is sick, you did everything possible to restore them to health, because you were not told to reserve."

Today, Reinhardt continues, that key is being taken back, and both physicians and hospitals are becoming increasingly accountable to those public and private insurers who are paying the bills. One reason the old system came into question is that studies showed large variations in utilization of health care services. For instance, says Reinhardt, "in Iowa, they were finding that in some areas half as many hysterectomies were being done as in others. That data raises questions in the minds of a lot of people."

But an even greater impetus is the massive change in social values now underway. "Americans today on the average are more selfish, narcissistic and concerned about 'making it' than they are about fairness and equality," he said. "The Yuppie generation no longer wants to be its brother's keeper," he says.

In the past, Reinhardt says, physicians and hospitals were able to care for the poor not eligible for government assistance through cost-shifting. Today, however, with increased accountability, utilization review and DRGs, cost-shifting has become impossible, so that those without insurance coverage or the ability to pay may be left without care. "In a period when we have too many doctors and too many hospitals, a three-year-old comatose girl is denied access to health care because she has no insurance," says Reinhardt. "That's what we have come to."

So how can the situation be resolved? Through rationing and publicly financed health care, Reinhardt suggests. "Every American — just by being an American — should be insured for a basic coverage — and this should be publicly financed," he says. "We need one tier of health care for the bottom 90% of the population and another tier for the top 10% who are willing and able to pay more."

But a publicly financed health care system is not a popular idea in this country, Reinhardt recognizes. Physicians and patients alike continue to fight for free enterprise in the health care system.

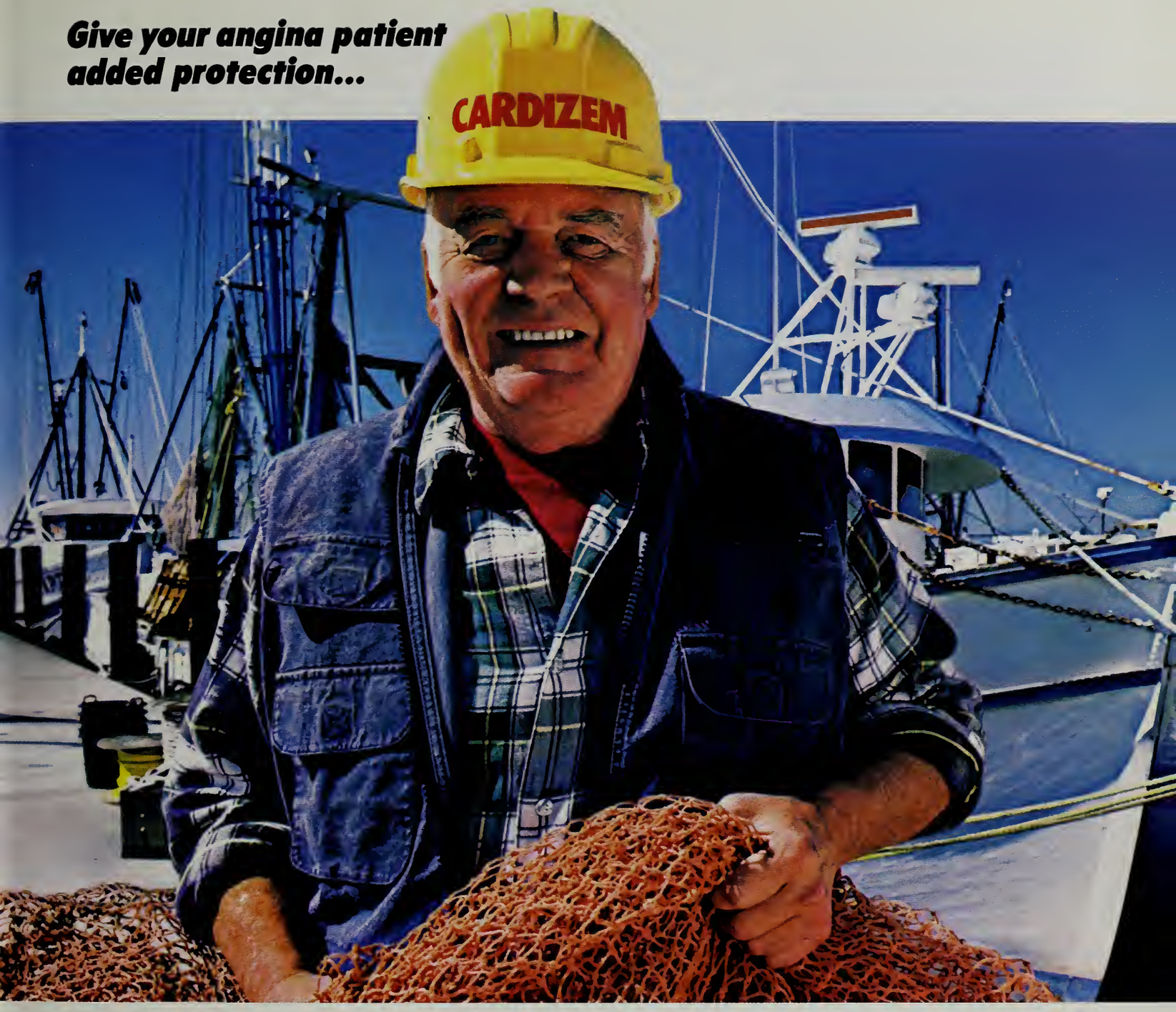
The exchange, however, may be the clinical freedom physicians have prized over the years. "Surveys show that whenever physicians lose their economic freedom they are more clinically free," Reinhardt comments. Likewise, maintenance of economic freedom often leads to restriction of clinical freedoms, as government and big-business get involved in deciding when and what care is appropriate. "No German physician would accept what's being done routinely to you," he says, referring to the stiff utilization review procedures now being implemented.

Still, says Reinhardt, physician incomes will remain secure as more and more care takes place in the doctor's office, rather than in a hospital setting. "Less hospitalization works in favor of the physician because it shifts interaction to the practice," says Reinhardt. Thus, in the future, he says, the "modern medical practice will be more elaborate — there will be much more equipment in the physician's office and much more physician income will come from owning that equipment — income that used to go to the hospitals."

Even the physician surplus will not cut into physician incomes, Reinhardt believes. "Physicians will always do well financially."

In addition, physicians receive a bonus — that sense of accomplishment and self-satisfaction that comes from being of service to one's fellowman. Says Reinhardt, "When you're a physician, there's no question that when your life comes to an end, you will know that you made a difference — and that's a 'psychic income' that can't be taxed." — *Susan Porter*

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BRIEF SUMMARY

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist).

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM (diltiazem hydrochloride) in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

CARDIZEM 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other. Issued 4/1/84

See complete Professional Use Information before prescribing.

0642T5

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For years, scientists, medical experts and researchers have been wrestling with the question of a "cancer diet." Does one exist, and, if so, what foods should be included — or excluded — to avoid the risk of cancer?

The American Council on Science and Health claims, in its booklet "Diet and Cancer," that there is "insufficient evidence" at the present time to establish any type of dietary policy for the American public.

But Richard S. Rivlin, MD, chief of nutritional services at Memorial Sloan-Kettering Cancer Center in New York, believes differently.

"We can't afford to wait until all the answers are in — until all the t's are crossed and all the i's are dotted," he said, at a recent meeting held by the Cancer Control Consortium at St. Elizabeth Medical Center in Dayton.

According to Dr. Rivlin, numerous epidemiological studies done in this area indicate that there *is* a correlation between diet and health. For example:

*Studies indicate that a high incidence of cancer can be attributed to a high intake of dietary fat. The American diet, which is made up of some 40-45 percent fat, is "far too high in fat intake," and "every effort should be made to reduce it," says Dr. Rivlin.

*Preliminary evidence now show that a lack of calcium may be instrumental in the development of colon cancer.

*Other studies now give scientists reason to believe that a lack of vitamin A causes epithelial tissue to grow in an unrestrained manner — a factor which could lead to cancer. (The vitamin A contained in the fish oil consumed by Eskimos is thought to be the reason cancer is rarely seen in this race — despite a diet composed of nearly 75 percent fat.)

*Studies increasingly indicate a lifetime of exercise may help prevent cancer.

Ultimately, diet is a "manner of living, a way of life," says Dr. Rivlin, and how you choose to live and eat may matter significantly to your health, he says. — *Deborah Athy*

Toledo student takes OSMA Science Award

An 11-member judging team, comprised of members of the Ohio State Medical Association and chaired by D. James Hickson, MD, of Mt. Gilead, awarded Jill E. Thomley of Toledo the OSMA's award for best exhibit with medical science orientation, during the 38th Annual State Science Day competition, held this past April in Delaware.

Thomley, a senior at Toledo's Woodward High School, had exhibited "The Effects of Whole-Body Hyperthermia, Chemotherapy and Combined Whole-Body Hyperthermia and Chemotherapy on Normal Animal Tissue" during the one-day event sponsored by the Ohio Junior Academy of Science, a branch of the Ohio Academy of Science.

The OSMA judges also selected winners in Grades 7-11, presenting each with a framed certificate of achievement. Thomley was presented with a plaque and savings bond.

The OSMA judging team consisted of:

D. James Hickson, MD, Mt. Gilead — Chairman
Melanie Kennedy, MD, Columbus — Vice-Chairman
Katherine N. Dixon, MD, Columbus
Louis J.R. Goorey, MD, Columbus
William G. Wasson, MD, Canton
Judy Westman, MD, Columbus
Thomas E. Shaffer, MD, Columbus
David Smith, Jr., MD, Delaware
Elizabeth R. Aplin, MD, Columbus
Charles E. Casto, MD, Stow
and Thomas D. Halliday, MD, Marietta. — *Bob Clinger*

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The First Session of the House

By Karen S. Edwards

Photos by Doug Evans and Susan Porter

"Where do we go from here?" That question, this year's Annual Meeting theme, seemed to reverberate over Dayton, Ohio this past May, as delegates and alternate delegates from throughout the state convened at the Stouffer Hotel and Convention Center in the "Gem City" to consider a new crop of resolutions and to induct the association's new president, John E. Albers, MD.

Friday night, at the First Session of the House, the theme echoed again and again as reports were presented from PICO, OMERF, Membership, the Women's Auxiliary, and from 1985-1986 President, Herman I. Abromowitz, MD.

In remarks before the House, guest John Clowe, MD, vice speaker of the AMA's House of Delegates, said that the AMA itself is asking the question, "Where do we go from here?" with regard to the present liability crisis.

"We are driving for tort reform," he said, reporting that, to date, 12 states have already been successful in achieving that goal — and although he recognized that a lot of work still lies ahead for the organization in this area, he spoke optimistically about the outcome.

He was less optimistic, however, about the direction in which health care, specifically the private practice of medicine, is headed in this country, with the proliferation of alternative delivery systems.

"By the year 2000," he told the House, "every one of you will, in some way, be attached to an HMO or an IPA."

However, he applauded the efforts being made by local county medical societies, like Columbus and Cincinnati, in organizing their own systems.

"We have found that the smaller systems such as these are generally better than those owned by larger corporations, since they retain more physician control," he said.

The topic of professional liability and "where do we go from here?" was back before the House moments later, as Cleveland physician John G. Gaughan, MD, Chairman of the Board of the Physicians Insurance Company of Ohio, stepped to the podium to present PICO's annual report.

According to Dr. Gaughan, PICO is sensitive to the problems currently besetting the professional liability field — "We recognized that there were problems before there *was* a crisis," he commented — and he assured the House that any raise in PICO's rates during 1986 would be below 25 percent.

Dr. Gaughan also mentioned that the recent take over of a floundering Florida-based malpractice insurance company has met with great success for PICO's subsidiary company, Physicians Management Corporation.

"Although the professional liability problem has not yet been resolved or stabilized, PICO will continue to maintain its excellence of service to its subscribers," he said.

And, in reassuring the House that the present "crisis of affordability" would not be turning to one of "availability" as well, he added: "PICO will be around to pay claims when the need arises."

Oscar W. Clarke, MD, of Gallipolis, wears numerous hats

The First Session

continued

during the association's annual meeting, but it was his position as Chairman of the Board of the Ohio Medical Emergency Research Foundation (OMERF) that brought him before the House Friday night. Dr. Clarke said that OMERF now has $127,065.60 in its fund as a result of various fund-raising efforts.

One of the most interesting answers to the question "where do we go from here?" came from Thomas Morgan, MD, also from Gallipolis, who is Chairman of the OSMA's Committee on Membership and the keynoter for the Physician Outreach Program — a member recruitment program that was introduced at last year's Annual Meeting.

Dr. Morgan believes that where the OSMA "goes from here" will depend, to a large extent, on how successful it is in recruiting new members.

"Membership is the name of the game," he said. "It is the lifeblood of the association, and we must actively recruit non-members if we are to survive."

He pointed out that, on first glance, it appears that OSMA's membership has increased substantially during the last five years. In 1975, for example, the OSMA had a total of 10,800 physician-members. By 1980, that sum had increased to 19,000. But much of that figure must be attributed to the number of medical students and residents whose membership is paid for them, says Dr. Morgan.

"If we were to look at the 1985 figure for the number of active, practicing dues-paying physicians this Association has, the figure would be closer to 11,400," he said — not much different from the 1975 total of 10,800 members.

"When you look at these figures in this manner, you can see that OSMA's membership growth has remained stagnant over the last ten years," he said.

Adding to the problem is the increase in the number of physicians retiring from practice.

"In 1980, 1200 members had retired from practice. This year, we have 1900 members listed as retirees," Dr. Morgan pointed out, adding that more members must be brought in to take their place.

"Fifty-two percent of our members are between the ages of 40 and 65," said Dr. Morgan, "and only 34 percent of our membership is under 40. If this trend continues, and as more of our members retire, we will soon reach the point where the OSMA will not be representing the majority of physicians in this state." Currently



Thomas A. Morgan, MD, Gallipolis, at the podium, introduces (l. to r.) William Paul, MD, Columbus, and Donavin A. Baumgartner, Jr., MD, Cleveland, to the House. Both were top winners in the Physician Outreach Program.

the OSMA represents slightly over half of all licensed physicians in Ohio. "That's why the Physician Outreach program is so important," he said.

Last year, the Physician Outreach program brought 87 new members into the Association. Dr. Morgan recognized William Paul, MD, a Columbus physician and Donavin A. Baumgartner, MD, a Cleveland physician and OSMA district councilor, as last year's top recruiters, bringing in 22 and 11 new members, respectively. He also recognized five "third-place" winners who each enrolled three new OSMA members.

Dr. Morgan went on to applaud Fayette, Geauga, Harding, Madison, Monroe, Ottawa, Perry and Shelby counties as having 100 percent OSMA membership.

"Last year, 120 members participated in the Physician Outreach Program. This year, let's make that figure even greater," he urged.

Recruiting members was also a priority of the OSMA Auxiliary, said 1985-1986 President Dee Talmadge, in her report before the House.

"Last fall, I challenged the President of the Illinois Medical Auxiliary to a membership campaign," she said. Currently, the Ohio Auxiliary — nearly 5000 members strong — is the fifth largest Auxiliary in the country, behind California, Texas, Florida and Pennsylvania. Illinois is closing rapidly behind Ohio as number six.

However, said Mrs. Talmadge, "as of today, it appears we shall be declared the winners at the National Convention."

Increased membership wasn't the only factor that made this year a stellar one for the Auxiliary, Mrs. Talmadge hastened to add.

AMA-ERF contributions set new records, exceeding the Auxiliary's goal of $65,000 by at least $5,000, making Ohio the fourth largest state in AMA-ERF contributions in the country . . . health education and health projects were also introduced . . . and the Auxiliary entered into a coalition this year with the American Federation of Aging Research/Ohio Affiliate to enable a statewide launch into the research of aging.

Mrs. Talmadge also mentioned the Auxiliary's political involvement, highlighted by the successful "Day at the Legislature" program which, this year, featured a new "grass roots approach." And she spoke of a "continued positive promotion of communication" between the Auxiliary and the OSMA itself.

Also in terms of "where do we go from here?" Mrs. Talmadge pointed out that, beginning in September, a state auxiliary marketing team will be traveling Ohio, "promoting and recruiting for medicine."

She concluded by thanking everyone who helped make this a "dynamite year" for the Auxiliary.

Concluding a "dynamite year" on his own, 1985-1986 OSMA President, Herman I. Abromowitz, MD, gave his Presidential Address before the House during the final moments of the First Session.

Dr. Abromowitz, who was stepping down from office in his own hometown, was the one who refocused the House's attention on the question "Where do we go from here?" — providing it with perhaps one of the most poignant and thoughtful answers.

He began his speech by comparing the theme "Where do we go from here?" to a Peanuts cartoon he had seen — where Charlie Brown and Lucy are standing on the deck of a cruise ship studying the deck chairs that lie about.

"Lucy says that choosing a deck chair is very important. Some people like to face the stern of the ship to see where they have been, and other people like to face the bow to see where they are going," related Dr. Abromowitz.

"Lucy asks Charlie Brown which way he wants his chair to face, to which Charlie Brown replies: 'I haven't even been able to unfold the darn thing yet!'

"I am sure many of us, like Charlie Brown, are still trying to unfold *our* deck chairs," he said.

When evaluating medicine, "do we look back to the past to see where we've been — or do we look ahead to the impending — and alarming — changes that wait ahead? Where do we go from here?" he asked.

His answer was that "we must look into the future with dedication and rededication to the commitment of being a caring profession — with quality as our guiding beacon" — but "we must never forget that the heritage of the past is a great and mighty teacher."

He reflected on some of the

continued on page 449

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The First Session

continued

OSMA activities that have taken place this past year . . . in the legislative arena, with the nurse practice act, medical board legislation with the OSMA's participating in the special program known as PADS — the acronym for Prescription Abuse Data Synthesis. The PADS program helps to identify and eliminate sources of illegal prescription drug diversion in Ohio.

He mentioned OSMA's continuing involvement in the professional liability crisis — recognizing the work of the Professional Liability Task Force and its new coalition with the Ohio Hospital Association and the Ohio Osteopathic Association. He spoke, also, of educating the public on the facts surrounding the crisis, and urged members of the House to inform themselves on the issue by studying the Professional Liability Communications Kit prepared by OSMA's Department of Communications.

He recognized PICO for its leadership role throughout the country, and spoke highly of OSMA's public education campaign, the association's involvement with community health fairs, and its continued success with the mini-internship programs, being offered on the county level.

"This has been an active year . . . however, as we go forward, I have to admit that I am personally troubled and concerned about what appears on medicine's horizon," he said.

He expressed concern over those who would make medicine "a business and not a profession."

"Medicine is not just another commodity," he argued. "Medicine stands alone and is unique. Quality, not cost, is the bottom line," he said.

"Obviously, fear of rising health care costs is a major force in our society today," he pointed out, adding that fear is driving patients and physicians into managed health care systems.

"We cannot, however, let fear rule our lives, or our health care system," he said.

In conclusion, he told the House:

"As I fix my deck chair, facing the future, one thing is crystal clear — we must never let the profit motive supercede quality in health care.

"Let us, as physicians, the greatest ally and advocate for our patients, ensure that quality medical care is first, foremost and always."

Dr. Abromowitz received a standing ovation from the floor of the House.

The First Session adjourned shortly thereafter. **OSMA**



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The Final Session of the House

By Susan Porter

Photos by Doug Evans and Susan Porter

The professional liability crisis, trauma centers, the National Health Service Corps' private practice option, increased government regulation and its effects on health care, and a full-time director for the OSMA's impaired physicians program — all were topics of considerable debate during the final session of the OSMA House of Delegates held Sunday, May 4.

Following a day of reference committee hearings during which a total of 50 resolutions were openly discussed, the 206 delegates who attended the final session considered 37 proposals, including Substitute Resolution 35-86 which brought a round of applause.

Similar to action taken recently by the American Medical Association, that resolution gives OSMA's support of "a tobacco-free society by the year 2000" and calls for the enactment of a number of new OSMA policies. These include prohibiting smoking at all OSMA-sponsored meetings, developing a proactive non-smoking policy for OSMA membership and staff, and supporting legislation to:

*control smoking in public places

*prohibit vending machine sales of cigarettes and tobacco products

*set the minimum legal age for purchasing tobacco products at 21

*raise the federal excise tax on cigarettes

*prohibit the sale of tobacco products in health care institutions, and

*ban smoking on all commercial airline flights within the US.

The resolution also commends the cities of Xenia and Cincinnati for enacting ordinances to ban smoking in public places and calls for more educational programs aimed at informing school students and young adults about the health hazards associated with tobacco use.

Another resolution adopted with the widespread support of the House of Delegates allows the OSMA Medical Student Section to elect an alternate delegate to the AMA. "The OSMA Council has been impressed with the enthusiasm and dedication shown by Ohio students in the Medical Student Section of the OSMA," says the resolution, which amends the OSMA bylaws to permit a medical student to serve as alternate delegate.

Other resolutions approved by the House encourage members to: acknowledge living wills in determining care for their terminally ill patients; protect the rights and privileges of all physicians licensed in the state, regardless of their ethnic or educational backgrounds; and support legislation protecting freedom of choice of physician for those participants in government-sponsored health care programs.

The House also voted unanimously to support the basic concept of a national computer tracking system, so that state licensing boards will know when and why physicians' licenses have been revoked, suspended or reinstated in other states. In

another resolution, the House commended the OSMA Legislative Committee, Legislative Department and the Department of Legal Services for their work on House Bill 769, which strengthens the disciplinary powers of the State Medical Board. And in Resolution 41-86, it asked OSMA to continue to work with the State Medical Board in developing regulations for the safe and appropriate use of amphetamines and methamphetamines.

Medical Professional Liability

Of the 37 resolutions placed before the House of Delegates for a formal vote, 15 were approved, four were defeated, four were placed on the consent calendar, one was put on file and 12 were referred to the OSMA Council for further study.

Among those forwarded to the council was Substitute Resolution No. 17-86, which would have set aside $500,000 to $1 million to support public education and legislative tort reform in the Ohio General Assembly regarding the current professional liability crisis.

Items listed for tort reform include limiting non-economic damages (pain and suffering, mental anguish, etc.) to a "fair and reasonable maximum dollar amount," mandating structured settlements, reducing awards in cases where a plaintiff can be compensated by collateral sources, limiting attorney's contingency fees, redefining the statute of limitations to prevent the possibility of open-ended liability, and creating disincentives for frivolous lawsuits.

After lengthy discussion, however, the resolution was referred to the council and the OSMA Task Force on Professional Liability which has been struggling with all of these issues for the past year.

"We're not saying that we don't want all of this," Donavin A. Baumgartner, Jr., MD, the Fifth District Councilor explained, in asking that the matter be referred. "What we are saying is that it needs more study, and all of this already is under active discussion by the (professional liability) task force."

The House of Delegates did approve, however, Resolution No. 15-86, regarding the so-called "million dollar umbrella," or mandates by some insurance companies that physicians on hospital staffs carry at least a



Stewart B. Dunsker, MD, Cincinnati, rises to make a point during the Final Session of the House.

The Final Session

continued

million dollars in professional liability coverage. The resolution asks the OSMA to work in cooperation with the Ohio Hospital Association to develop guidelines specifying the rights of both hospital boards of trustees and hospital medical staffs regarding professional liability. It also voices OSMA's opposition to those insurance companies and hospital boards which unilaterally require all physicians — regardless of specialty or type of practice — to carry a specific dollar amount of insurance as a condition of membership on a hospital staff.

A third resolution dealing with professional liability was defeated. It would have established a computer network to identify those persons who have filed one or more lawsuits against physicians or hospitals, similar to the "Physician Alert" program in Los Angeles.

Trauma Centers

Also drawing a lot of discussion was Substitute Resolution 20-86, calling for the establishment of a non-profit board or entity to categorize hospitals according to their ability to handle trauma cases.

Those in favor of the resolution pointed out that recent studies indicate 20% to 25% of all deaths from trauma could have been prevented if emergency care had been delivered in an optimal care setting. Both Oregon and Pennsylvania have enacted legislation to establish boards to review and certify hospitals as "trauma centers," they stated.

Those in opposition to this type of categorization were largely from smaller hospitals throughout the state who feared that emergency rooms not meeting the criteria for "trauma centers" would suffer.

"Physicians like myself feel very threatened by this type of thing," said one individual testifying against the resolution. "Those hospitals in the larger cities with 1,000 beds aren't going to be hurt by this," he said, "but those of us in 150 to 180 bed hospitals who are doing a good job are going to be penalized."

"Sometimes the quickest place you can get to is the best place to go if you're interested in saving a life," said another who spoke out against the resolution. "My fear is that we'll be driving by an emergency room that could have enabled the patient to live long enough to make it to the next center," he said.

Those in support of the resolution, however, claimed that small hospital emergency rooms could still be utilized 95% of the time. "We're only talking about those 5% of the cases where multiple systems injuries have occurred — where the injuries are of such severity that a good hospital emergency room would be



Delegates await their turn at the microphone during one of the discussion periods preceding the final vote on one of the 50 resolutions considered by the House.

overwhelmed," said one in favor of the resolution. "These are the cases where you must get the patient into the operating room within minutes — that's what trauma centers are for."

The resolution was eventually referred to the OSMA Council, however, due to fears that setting up a board to oversee such categorization might result in unnecessary regulation and government bureaucracy.

Private Practice Option

Another government program to come under fire was the National Health Service Corps (NHSC) and its Private Practice Option. This option allows individuals who have gone to medical school on NHSC loans to pay back the government by setting up private practices in those areas designated as health manpower shortage areas.

The resolution was introduced largely in response to a situation in Sandusky County which has been designated a health manpower shortage area by the NHSC. Medical societies in Sandusky and Ottawa counties believe the area has been unjustly listed as a shortage area, claiming 17 physicians in primary care practice were not included in the practice data survey. As a result, several new physicians are scheduled to begin practice under the Private Practice Option in Sandusky County this August.

A number of physicians testified regarding the NHSC and the manner in which shortage areas are defined. One physician who completed school with a NHSC loan said that she will owe the federal government $120,000 as of June 30, because the rural area where she has set up her practice is no longer classified a shortage area.

Other physicians testified that the NHSC refuses to consult with the OSMA or the county medical societies for input on shortage areas, and that due to over-recruiting in the program, physicians are being sent to areas that have no need of them. Thus they are unfairly competing with physicians who have established a practice without NHSC support.

Still, the Private Practice Option serves a very real need, said physicians from several counties with physician shortages. "We once had 12 physicians and now we have only six," one said. "We are overworked and we need these physicians now."

The House approved, however, Emergency Resolution 05-86, which asks for an immediate review by the US Public Health Service of the Sandusky County situation. It also calls for the OSMA to work aggressively for the cancellation of the Private Practice Option portion of the NHSC program.

Increased Regulation

Much debate also centered on a number of resolutions which deal with the increased amount of regulation physicians now face. Among items addressed were mandatory second opinions, preadmission certification, the Medicare fee freeze, physician reimbursement for home health care and same day admission procedures for surgery.

Many third-party payors now require second surgical opinions prior to the performance of an elective surgical procedure, Substitute Resolution No. 04-86 points out. However, patients frequently do not know about or understand these requirements.

While stating it was not in favor of mandatory second surgical opinion programs, the resolutions committee which reviewed the proposal suggested its adoption, asking the AMA to seek standardization of administrative procedures for all mandatory second surgical opinion programs. The resolution also urges those third-party payors requiring second surgical opinions to educate their subscribers about these requirements.

A second resolution regarding mandatory second opinion was more direct in its views on the process, stating, "No objective data exists that a second opinion is cost effective or assures quality of care." It went on to state that it is inappropriate and unethical for a physician giving a second opinion as part of this requirement to then assume the continuing care of the patient.

Some physicians testified, however, that patients may seek a second opinion on their own, rather than at the request of their insurance companies. Prohibiting that physician from rendering care may conflict with patients' rights to select physicians of their choice, they pointed out.

Due to the complexity of the issue, the resolution was referred to the OSMA Council for further study.

Preadmission certification is another requirement of many third-party payors that is confusing to patients and physicians alike. The House therefore passed

The Final Session

continued

Resolution 06-86, asking the OSMA to urge the AMA to seek standardization of administrative procedures for preadmission certification programs, including both the administrative requirements to be met and the forms to be completed.

Referred to the OSMA Council was Resolution No. 07-86, which asks the OSMA and AMA to implement programs to inform the public that the "payments for the care of Medicare patients are restricted and that quality and availability of care are threatened." The matter was referred at the resolutions committee's suggestion, because "the thrust of this education should be more universal in its scope, rather than directed only at the Medicare freeze."

Resolution No. 08-86, regarding physician reimbursement for home health care, was another topic of considerable debate. "Home care after hospitalization is becoming an evermore frequent disposition for the patient," the resolution points out. Yet "physicians are reimbursed for home health care by Medicare and other third-party carriers at a rate considerably lower than that received by nurses and other allied health practitioners providing home health care."

Some testified that physicians should work with other allied groups to determine what is a fair reimbursement rate for home health care visits. However, the issue is not what others are reimbursed, but what physicians are allowed to earn for delivering care in the home, it was stated.

The resolution therefore was approved as amended, stating that the OSMA should "petition government and other third party carriers to allow for equitable remuneration consistent with services rendered by physicians for time involved in treating patients at home . . ."

Stirring up even more controversy was Resolution No. 13-86, regarding same day admissions procedures for surgery. Some third-party payors now deny benefits to the insured for pre-operative admissions, the resolution points out, in some cases jeopardizing prompt uncomplicated recovery from surgery. The attending surgeon or physician "is best qualified to determine the timing of a patient's admission," the resolution states, "and arbitrary lists of admission day procedures may lead to less than optimal patient care."

However, those testifying before the reference committee largely spoke in opposition to the resolution because they felt it was unnecessary. In many cases, same-day admissions procedures are acceptable to physicians, and patients are pleased with this speedup of care, they said. In those cases where additional time for work-up is necessary, a mechanism for allowing earlier admissions is available, they added. The matter was thus referred to the OSMA Council for further consideration.

Two other resolutions referred to the council include one which calls for the establishment of a medical voucher system for the Medicaid program and another voicing support of the Medicare Quality Protection Act of 1986. The latter, among other provisions, asks the Secretary of Health and Human Services to improve the DRG payment system to cover the cost of hospitalization for severe and prolonged illnesses and mandates that PROs evaluate quality of care, rather than focusing solely on cost.

Also dealing with the quality of care issue was Resolution 12-86, which would have set aside $20,000 for the OSMA, through its staffing and committee system, to develop



Roland A. Gandy, MD, presents the report of Resolutions Committee #2.

a reporting mechanism to evaluate any reduction in quality of care delivered which may have resulted from the many restrictions implemented by government and third-party payors. While the committee felt the thrust of this resolution was good and that the data would be valuable, it referred the matter to the OSMA Council due to the cost and complexity of implementing such a program.

Full-time PEP Director

A full-time director for the OSMA's Physician Effectiveness Program (PEP), which aids those physicians suffering from drug and alcohol abuse problems, was the objective of Amended Resolution 43-86. That resolution would have set aside a minimum annual budget of $250,000 for the program, to include the medical director, two specially trained assistants, a secretary, office facilities and supplies.

The money was to be raised by special assessment of the membership plus matching funds from insurance companies. However, the issue was referred to the OSMA Council so that other funding alternatives could be explored.

"As a past OSMA president and membership chairman, I feel we can not afford any more dues increases while attempting to get more members into the association," said Thomas Morgan, MD, in asking that the matter be referred.

Others feel that in view of the professional liability situation and the impending need for funds for that cause, "We have our priorities mixed up. We already are looking at an individual solicitation

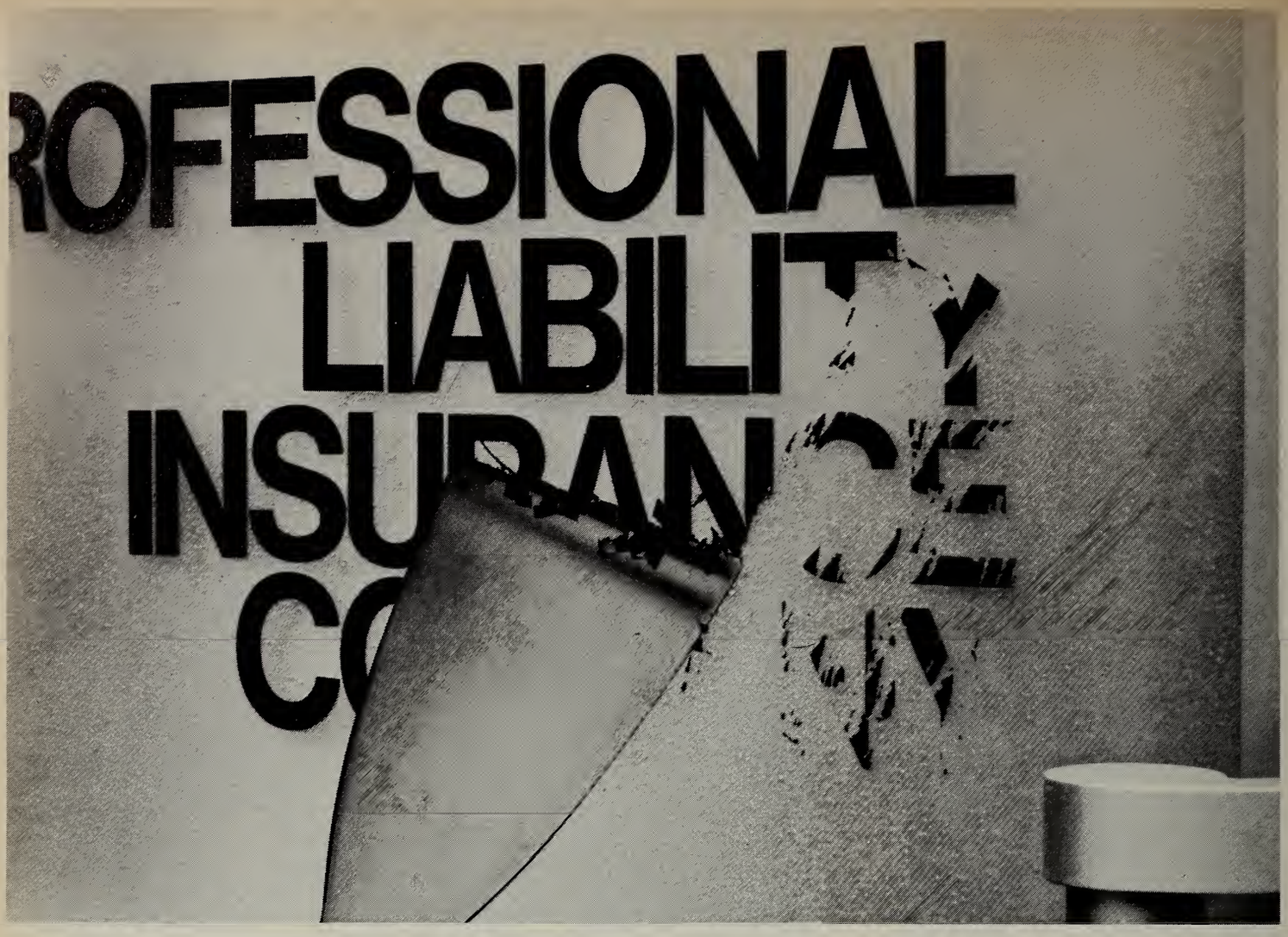
The Installation of John E. Albers, MD



Herman I. Abromowitz, MD, Dayton, presents John E. Albers, MD, Cincinnati, with the Presidential Medallion.



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The Final Session

continued

program to beef up funds for the professional liability effort," one said.

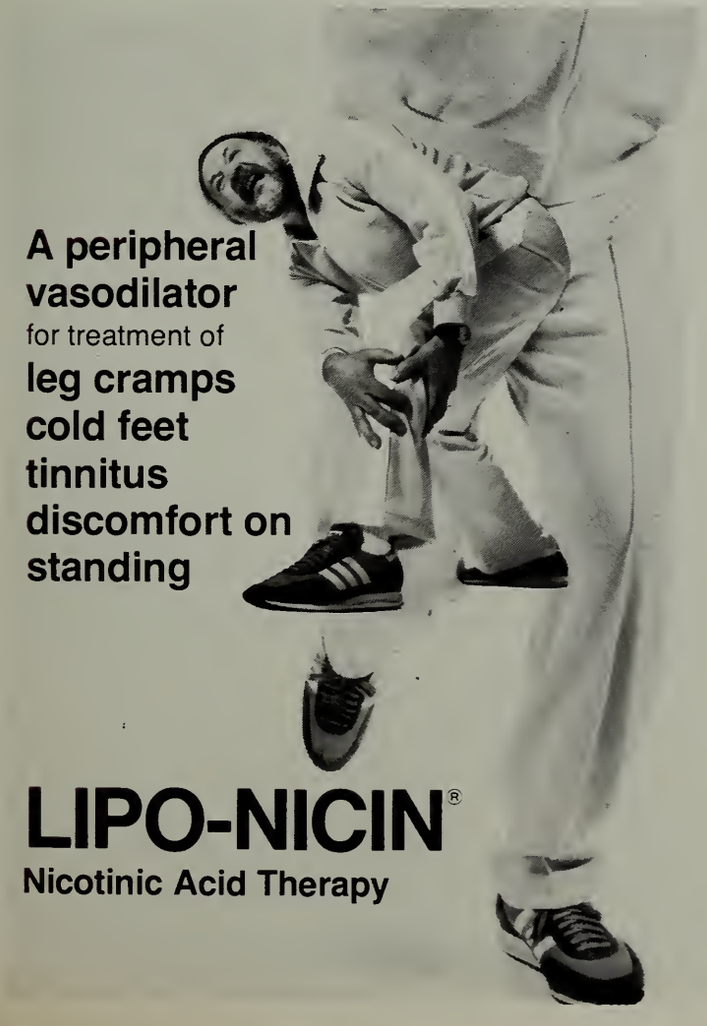
Among those contributing to the current liability situation are impaired physicians, a supporter of the resolution pointed out. Some 1650 Ohio physicians and their families and patients would directly benefit from the program, while countless others would be spared potential problems in dealing with impaired physicians.

"Our program is 10 years old and we are dealing with 25 cases on a volunteer basis each year," said one proponent of the resolution. "We could be doing eight times this number if we had a full-time director and the appropriate staff."

"Clearly we are all in favor of resolving this problem," said H. William Porterfield, MD, Councilor from the 10th District, "and if having a full-time staff to do it is the step we have to take, that's what we'll do." He and others, however, voted to refer the matter to the OSMA Council in hopes of finding a better way to fund the program. **OSMA**

NOTICE

The Journal Minutes of both the First and Final Sessions of the House of Delegates, OSMA Annual Meeting 1986, will be published in the August issue of the OSM Journal.



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Peptic Ulcer Update

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effects have appeared in the European literature. The final word on the side effect profile of ranitidine compared with cimetidine undoubtedly awaits a much greater experience with the agent in this country.

The relative lack of popularity of sucralfate, compared with H_2-antagonists, is puzzling. This nonsystemic agent is effective and approved for short-term treatment of duodenal ulcer. Neither an antacid nor an inhibitor of acid secretion, it has several novel mechanisms of action. These include binding to exudates in ulcers but not to normal tissue, inhibition of pepsin, binding of bile salts, and exclusion of acid from ulcer sites. Several studies have shown that a sucralfate dose of one gram q.i.d. before meals and at bedtime confers healing rates in duodenal ulcer equal to cimetidine, with similarly effective control of symptoms. Sucralfate is minimally absorbed and thus has little potential for systemic side effects. One or two percent of patients experience constipation from sucralfate. Drug interaction is limited to intraluminal binding and delayed absorption of a few agents, which can be avoided by not administering them at the same time as sucralfate. Newer data extend both the mechanisms of action and possible therapeutic indications. Animal studies have shown it to be cytoprotective against a variety of injurious agents, probably because of increased mucosal prostaglandin. Application of these observations to human subjects have resulted in healing of gastric ulcers as well as protection against bile reflux, stress, and NSAID-induced gastric erosion, and ongoing studies in progress are examining its place in therapy for reflux esophagitis and for prophylaxis of ulcer. While only duodenal ulcer is a presently approved indication in this country, the expectation that other mucosal lesions may be prevented or more effectively treated by sucralfate will add a new dimension to existing therapy.

New classes of drugs under clinical evaluation include orally active prostaglandin analogs and omeprazole, a substituted benzimidazole. The former are anti-secretory and cytoprotective agents that have been effective anti-ulcer agents in early trials. Omeprazole is a potent inhibitor of parietal cell hydrogen ion secretion, which is currently being studied in the medical treatment of the Z-E syndrome. In addition, more powerful H_2-receptor antagonists are being developed and tested. The need for such agents as well as their safety and effectiveness remains to be established.

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How to Manage Your Patient's Psyche (even though you're not a psychiatrist)

By I.C. Sharon, MD

Since the majority of patients coming to a physician have a primary emotional disturbance or a large emotional overlay to some organic illness, the successful handling of psychological factors is one of the most important tasks in the practice of medicine. Many organic conditions actually produce no symptoms until the patient is made aware of their existence. Every successful doctor practices some degree of effective psychological management whether he is aware of it or not. It is not a question whether the medical practitioner should deal with psychological problems. It is only a matter of how well he can cope with them. The doctor who has not attempted to develop a positive psychotherapeutic approach loses much of the gratification of the practice of medicine and deprives the patient of the best medical care. Even referring a patient to a psychiatrist requires psychological management. The patient can sense the rejecting tone of the doctor who is trying to get rid of the patient by this referral.

The psychotherapeutic approach is the best assurance of obtaining the highest degree of therapeutic success. It promotes the greatest accuracy in reaching a diagnosis, and neither discourages a detailed search for organic disease by any available means nor precludes any treatment along surgical or medical lines. It builds a long-term doctor-patient relationship, based upon confidence and integrity, whereby the preventive aspects of medicine can ultimately be fostered in future visits.

Psychological management depends upon a positive doctor-patient relationship, which, by its very nature, acts as a therapeutic agent. Communication, both verbal and non-verbal, is the

A good doctor-patient relationship is based upon mutual confidence and trust . . . built up through frank discussion.

Managing your patient's psyche

continued

driving force in building this relationship. The quality of non-verbal communication of the doctor is related to his professional maturity and goes along with a caring attitude. Patients warm up to the doctor who has a relaxed facial expression and who maintains attentive eye contact. A good doctor-patient relationship is based upon mutual confidence and trust. Confidence does not arise from just a smile or a pat on the back, but has to be built up by an earnest desire for mutual understanding and through frank discussion. Many doctors are naturally gifted for psychotherapeutic practice by their warm personalities and by their ability to form quick relationships with people. This ability to influence patients by attitude and actions is the most important attribute of the psychotherapist. Providing a climate for communication cannot be overemphasized. Encouraging a patient to talk about himself or herself signifies a caring attitude. The doctor should avoid frequent interruptions as the patient reveals his or her history, but should ask the patient to elaborate on significant points. The doctor shows by a sincere, friendly, non-condemning manner that he or she is willing to help, and encourages the patient by this sympathetic attitude to relate personal problems and to express himself or herself freely. The doctor should talk less and listen more and avoid displaying feelings of anger or impatience. Doctor and patient should agree on what is being treated and work together. Education, reassurance and support are the areas of the non-psychiatrist.

The practitioner who feels ill at ease with a patient or interjects his or her own moods or inadequacies into the relationship will have difficulty in helping the patient psychotherapeutically. Patients get turned off by the seemingly uncaring doctor who rarely makes eye contact or the hurried doctor who keeps looking at a watch or shows impatience by tone of voice. Arguing with a patient promotes a poor climate for communication. Giving advice too quickly or writing a prescription prematurely before a symptom has been sufficiently explained can weaken a relationship. Ignoring a presenting complaint and focusing on some other area can be frustrating to the patient. The doctor should avoid prying and forcing confessions. Judgmental and moral values should be avoided. Patients should be encouraged to stress their abilities and minimize their disabilities. Franklin D. Roosevelt, with residuals of polio, is a good example. The successful handling of a patient's hostility can usually bring about an improvement in the doctor-patient relationship. In this connection the doctor should acquire a facial expression of repose and of interest and avoid lashing back or giving excuses. The doctor should avoid diagnosing psychiatric problems simply by the absence of organic findings, but should seek out emotional factors in relation to life events.

The physician is often the key figure in helping the older person cope with declining physical capacity, loss of close ones, inactivity and depression. With the decline in mental and physical functioning the oldster tends to withdraw to a narrower sphere of activity, resulting in a reduced feedback, so that the older person tends to derive less satisfaction from life and tends to become restless, irritable and depressed. It is paradoxical that although many older individuals suffer loneliness and depression from deprivation of close interpersonal relationships, these close relationships with people are poorly tolerated because of loss of self confidence and poor self image. Older people often feel what they have to say has no interest to others. The doctor who can become involved in a meaningful way with the older individuals can give them hope, comfort and motivation. All too frequently an older person is told he or she has arteriosclerosis and has to live with the symptoms. It is encouraging to the person who has been given this diagnosis to ask whether there have been any good days or even a few good hours and then respond that the same arteriosclerosis was present during these times, and point out that everyone over 50 has some degree of hardening of the arteries. A good attitude on the part of the doctor is more important than the length of time spent or advice given.

Chronic disease and terminal illness are no deterrence to the psychosomatic approach. Anyone

Providing a climate for communication cannot be overemphasized. Encouraging a patient to talk signifies a caring attitude.

who can carry on an intelligent conversation or who can respond to a twinkle of the eye or a smile is capable of having emotional problems altered in a beneficial way.

The non-psychiatrist, particularly the primary physician, and, indeed, any physician who deals with patients, can enhance psychotherapeutic skills if sufficiently motivated. Presentation of case material and discussions with professional psychotherapists can permit the practitioner to deal more effectively with emotional problems of patients. But there is no substitute for clinical experience and appropriate reading. **OSMA**

I.C. Sharon, MD, is a clinical professor emeritus of medicine, University of Cincinnati College of Medicine.

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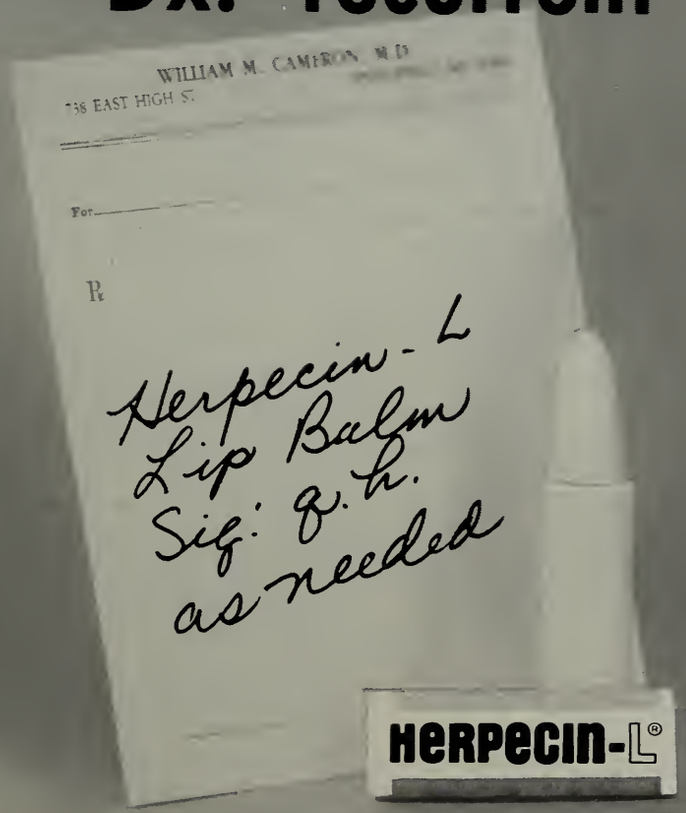
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OMPAC

OMPAC: Physicians' Voice in Government

PAC Board Chairman Discusses Reasons Doctors Should Join

By Tom Cashman

In mid-May the Ohio Medical Political Action Committee (OMPAC) launched the most extensive membership and fund-raising effort in its 22 year history. All full dues paying members of the Ohio State Medical Association were mailed the first of a series of appeals urging more physicians to join OMPAC. Current members are being asked to become sustaining members to increase OMPAC money available for use in this critical election year.

"The urgency of this year's OMPAC campaign stems from the immediate demands of the current political environment and by a need to boost poor political participation levels by Ohio physicians," says Jerome Kimmelman, MD, Chairman of the Board of OMPAC.

"The state legislature is now considering legislation that will affect the climate for the practice of medicine for the next several years," Dr. Kimmelman says. "There are many legislative issues putting doctors under the gun. We have to be prepared politically to fight effectively.

"All the forces in opposition to physician interests are poised for action in this session of the legislature," warns Dr. Kimmelman. "They are fully armed to work against us on health care legislation next year.

"It is very important that we raise additional resources from both new members and current members to help the friends of organized medicine get elected to public office. We must make sure the voice of medicine is heard."

Dr. Kimmelman said the goal for this year's membership program is to raise $150,000 by the end of September for use in the 1986 election campaigns.

"That goal may seem formidable," says Dr. Kimmelman. "But if each current OMPAC member were to recruit just one physician as a Sustaining Member of OMPAC, we would raise $250,000 — almost double our goal for the year."

Dr. Kimmelman noted that Ted Castele, MD, of Cleveland, obtained the pledges of more than 20 new OMPAC members from the Cleveland delegation to the May OSMA Annual Meeting.

"We're relying on the leaders of the OSMA, all presidents of the medical specialty societies, county societies and executive directors, in addition to the aggressive work of OMPAC board members to achieve this goal," Dr. Kimmelman said. "Peer to peer recruitment is the most effective means of raising money for political action committees."

In an interview with the **Journal,** Dr. Kimmelman discussed the importance of this year's OMPAC campaign and provided background into the important service OMPAC provides Ohio physicians.

Why is it important that physicians participate in OMPAC?

OMPAC is the voice of Ohio physicians in the political process. Participation by doctors in the governmental decision-making process is essential for promoting good government as well as quality patient care.

Let me explain.

Physicians are under tremendous pressure to alter the way they practice medicine. Issues facing medicine today, like scope of practice for other health care professionals, tort reform, physician fee freezes, mandatory assignment and the like, are decided in the political arena. The battle ground for dealing with these issues is in the state legislature, the Congress, the agencies that deal with the delivery of health care and now, unfortunately, the state Supreme Court.

The input of physicians is required when policy decisions are made. If physicians don't participate, the interests of quality patient care will be sacrificed or put at the mercy of non-medical decision makers.

How are OMPAC funds used to represent physician interests? How does OMPAC work?

As you know, OMPAC has a fee structure. Dues are established at multiple levels. The contribution for a Sustaining Membership is $125.00 per year. A Regular Membership is $100.00 and an Auxiliary membership is $35.00 per year.

The resources contributed by physicians and their families to OMPAC are collected in a fund completely separate from any other activity of the OSMA. Several



The Political Action Committee for the Ohio State Medical Association

times a year, the OMPAC board, which consists of twelve physicians, one from each OSMA district, two representatives of the OSMA Auxiliary and myself as Chair, meets with the legislative and legal staffs of the OSMA to discuss the present political and legislative environment. We analyze the political voting records to determine those elected officials who support medicine's interests.

We look at all this information and decide which candidates to support and how much money we can provide them. Our goal is to provide appropriate resources in the most timely manner so OMPAC member dollars will have the most impact.

This means we must make our contributions early in the "campaign cycle." It does us less good to support a candidate when our help would be too late to make a difference in winning an election. Nor is it all that useful to make a contribution when others are "jumping on the campaign bandwagon" and our support will not be strongly felt.

That's why this aggressive campaign is so important and why we need physicians' contributions to OMPAC very soon!

Why is it so important to join OMPAC right now?

Actually the answer is quite simple. The 1986 elections are upon us at this moment. 1986 is a critical election year for Ohio physicians. All major statewide offices are up for election, as well as all seats in the Ohio House and half the Senate and three positions on the Ohio Supreme Court, including the post of Chief Justice.

Important issues affecting the practice of medical care are being decided in the legislature now, too. Of particular interest to doctors are the discussions surrounding the very complex issues of tort reform and medical professional liability. We have to make our voice heard on these issues this year and next year.

Issues of concern to us this year and during the next legislative session will involve the full agenda of health care legislation and regulation, including medical professional liability, the role of allied health practitioners, medical ethical issues, medical education and the rapidly increasing intrusion of government into the traditionally sacred doctor-patient relationship.

We have to make sure the united voice of Ohio physicians is felt. We must make our voice heard in establishing policy in these areas and in many others. OMPAC accomplishes that.

How have Ohio physicians been doing so far with their participation in the political environment?

Not very well at all.

Far too few Ohio doctors are participating in OMPAC. Actually, on a per member basis compared to physicians in other states, Ohio physicians have one of the worst levels of political participation. Only 17% of the members of the Ohio State Medical Association are taking part in OMPAC. That is simply not enough physician participation to be an effective force in the legislature — especially when other individuals and groups, who threaten quality medical care, are participating in much greater numbers and often with greater individual contributions than Ohio doctors. We have to act now or we lose and our patients will lose.

A moment ago you mentioned professional liability, how can OMPAC participation affect this issue?

The issue of professional liability is on the front burner — both in the legislature and the national and state press — and it is certainly on the minds of all physicians. If doctors want to be heard and have their views represented on this issue, they ought to join OMPAC.

In the mid-1970s the OSMA led the way in legislation dealing with a wide range of professional liability reform. Already this year, some three dozen bills have been introduced in the General Assembly that affect the state's tort system, which has a direct impact on medical professional liability.

We have to be heard this time, too, or we'll lose out on tort reform. Given the current posturing going on now in the legislature, we may very well lose out to the interests of the plaintiff attorneys if we don't have our political act together.

We need to monitor these proposals to make sure medical interests are accurately represented. We cannot do that effectively without OMPAC.

Can you provide some historical background on OMPAC? Why was it created in the first place?

OMPAC was created in 1964 to support candidates for public office who recognize medicine's views and principles and who are open to input from organized medicine in setting public policy.

When OMPAC was formed, our mission was based on the realization that what happens in Washington, and in our state legislature in Columbus, determines the conditions under which physicians practice and that our stake in what happens is a big one . . . too vital to lose by default.

That mission hasn't changed in

continued on page 467

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OMPAC: Physicians' Voice

continued

20 years. But our task of getting physicians to participate remains quite difficult.

As Chairman of the Board of OMPAC, I've traveled the state extensively — talking to other physicians about the environment in which we practice medical care. Frankly, I hear a lot of complaining about government's role. It is something we all hear every day.

The trouble is, too few physicians are willing to do anything about it.

Well, some physicians in Ohio *are* doing something about it. We have supported OMPAC for the expressed purpose of providing access to get medicine's message across to our elected officials. And we've been very successful. But to stay successful, we need greater physician involvement.

My opinion is that those physicians who choose not to participate in OMPAC have little right to complain about what government is or is not doing. Joining and participating in OMPAC is as important as your vote. If you don't exercise your right to participate in the political process, you have no right to complain.

What considerations are taken into account before OMPAC provides money to a candidate?

There is no set formula really. But it is based on the analysis done by the OMPAC board which I have described and on information from many sources, including one to one knowledge of candidates by physicians, the OSMA staff, candidate public comments and so forth.

We look at a candidate's performance in office, in the case of an incumbent. And we look at the receptivity of a non-incumbent to the points of view of organized medicine. Our decisions are also based on a candidate's needs and, in our judgment, what it takes for us to effectively reach that candidate or office holder.

Does OMPAC buy votes?

No, absolutely not. OMPAC funds do not buy votes in the General Assembly. Perhaps this is the point where we should discuss what PACs really are and why they are necessary.

You see, corporations, as well as professional associations like the OSMA and, for that matter, practicing physicians groups, have established PACs or political action committees because corporate and business contributions are illegal for use in supporting political campaigns.

It is legal, however, for individuals to contribute to political campaigns themselves and for professionals to pool resources in support of the candidates of their choice.

What impact then, do OMPAC contributions have on legislation?

Like I said, OMPAC does not buy votes. Nor do our contributions guarantee we'll get our way every time we go before the legislature with an issue of concern.

But OMPAC funds are necessary to support the activities of the OSMA legislative staff. Our legislative program has been very successful over the years. We've overcome an onslaught of proposed legislation that has threatened our ability to provide the care our patients have come to expect, demand and deserve.

OMPAC helps elect those persons willing to listen to medicine's point of view; that gives us an open door to having an affect on the outcome of medical care legislation.

How does OMPAC facilitate physician participation?

OMPAC provides access for Ohio physicians to the governmental process.

To assure that our voice, the voice of doctors in Ohio, is heard in this arena, it is important that we help elect those persons most receptive to the interests of quality patient care and to elect those persons interested in developing and sustaining an efficient and fair system of medical care.

For physicians to be effective in the governmental arena, they need to bind together and speak as one voice for the issues of interest to them in the practice of medicine and the care of their patients.

With so many medical issues today being made in the political arena, I think physicians cannot afford not to be involved in the political process.

Physicians have to take every opportunity they can to make their voices heard or their competition, if you will, and the regulators will have their way without sufficient input from true medical care professionals.

There is no physician in this state who can say his or her practice is not worth $125.00 a year for representation in government policy. There really is no good excuse for not participating. **OSMA**

Tom Cashman is the Associate Director of the Department of Communications.

Claims Made vs. Occurrence: Another Insurance Crisis for Ohio Physicians?

Recent huge losses by U.S. and foreign reinsurance companies have caused a crisis in the liability reinsurance industry. Government and business organizations are experiencing extremely large rate increases and are being required to switch from occurrence to claims made coverage. Ohio physicians have faced crises before in liability insurance. The OSMA's insurance company, Physicians Insurance Company of Ohio (PICO), was formed to resolve an availability problem in the mid-seventies, and has grown and prospered because of its conservative, knowledgeable approach to medical professional liability insurance and other forms of coverage. Herbert E. Gillen, executive director of the OSMA, asked Joseph K. Gilmore, president of PICO, how this latest insurance crisis may impact on Ohio physicians. Mr. Gillen expressed particular interest in the difference between occurrence coverage and claims made coverage, and whether Ohio doctors will be forced to accept the claims made policy.

Gillen: Mr. Gilmore, without going into too much detail, what has caused the current liability insurance crisis?

Gilmore: Simply stated, primary insurers and reinsurers during the early-eighties underpriced their products because of competition, demand from policyholders for lower premiums, and the belief of some companies that investment returns from high interest rates would cover the inadequate premiums. Now we have a combination of rising claims and lower interest rates. Also, there is definite proof that claims settlements for all forms of liability insurance have risen far higher and more rapidly than anticipated because of liberal jury awards and a tort system that encourages lawsuits. All of the parties involved blame each other. In reality there is plenty of blame to spread around.

Gillen: How are Ohio physicians affected by this situation?

Gilmore: Fortunately, Ohio physicians have sources of coverage. Certainly, PICO is anxious to serve OSMA members through the OSMA Group medical professional liability insurance plan. The cost of insurance is higher than we would like and physicians would like, but rates reflect claims experience and trends. We hope that rate adjustments in future years will be as modest as possible. PICO's position has always been that we are in business for the long haul and we will not operate on the basis of possible short-term gain or market advantage. The financial dangers to Ohio physicians from medical malpractice claims are far too severe for their insurers to play games.

Gillen: What is PICO's position on occurrence versus claims made coverage?

Gilmore: Everyone agrees that the occurrence policy is superior to the claims made contract for the policyholder. An occurrence policy covers claims arising from a medical service provided while the policy was in effect, whenever the claim is reported. This covers the physician for the notorious long tail of malpractice claims.

Conversely, the claims made form covers claims only if it is reported while the policy is in effect. Thus, any claim reported after the policy terminates is not covered.

Gillen: Can the physician buy coverage for those claims?

Gilmore: Yes, he can purchase "tail" coverage. In fact, most claims made policies require that the insurer offer the policyholder tail coverage when the policy terminates. There is a one-time premium payment, which generally is quite high.

Gillen: We have heard the term "modified" claims made coverage. What does that mean?

Gilmore: The claims made policy is perhaps a little harder to sell than the occurrence policy because of the unknown cost of tail coverage that must be purchased at a future date. Some companies attempt to overcome this handicap by offering so-called "free" tail coverage if the physician continues his claims made policy until retirement, disablement or death, or by "guaranteeing" tail coverage. Of course, this locks the policyholder in the claims made program, making him or her subject to possible excessive future rate increases, and may still leave open the cost of tail coverage. Actually, any changes to the generic claims made form of contract results in a "modified" contract whether it works to the advantage of the policyholder or not.

Gillen: Could you explain that further?

Gilmore: Under the generic form of claims made policy, premiums start much lower than the cost of occurrence coverage, gradually escalate to a mature rate at year five, and continue on at the mature rate. First year rate is roughly 20 percent of the mature rate; second year rate is about 40 percent; third year rate is about 65 percent; fourth year rate is about 80 percent. A contract can be modified to the extent that persons entering the claims made concept do so at the mature rate, which is of enormous benefit to the insurer but of significant cost to the policyholder. Or, a company can establish a stable first year rate for two years, followed by immediate rise to the mature rate. Whatever contract is approved by the appropriate regulatory authority can be called a modified plan. In short, the company has a lot of latitude.

Gillen: Will PICO continue to offer occurrence coverage through the OSMA Group Plan?

Gilmore: Absolutely. We have no intention of switching the OSMA Group Plan to claims made coverage. We will never do so unless literally forced to take such action, and at the present time, we do not see that occurring.

Gillen: Has PICO ever offered claims made coverage?

Gilmore: We have, and we still do. The OSMA leadership requested that we offer claims made coverage back in 1979, to those physicians who for whatever reason desire that form, and we agreed to do so.

Gillen: Is there a place for claims made coverage?

Gilmore: In concept, occurrence is always better than claims made. But it appears likely that reinsurers will refuse to accept occurrence coverage for the highest excess limits of coverage. Thus physicians desiring several million dollars in coverage may have to accept the claims made form. The OSMA Group Plan offers limits up to $1.4 million/$1.8 million and that definitely will remain on an occurrence basis.

Gillen: How would you summarize the present situation?

Gilmore: From the insurance industry perspective, the best one word summarization is "predictable." Inadequate pricing always leads to future crisis and there is no question that some insurers and reinsurers were underpricing in recent years. However, the situation today is far worse because of the rapidly rising incidence of extremely large liability judgments.

Another Insurance Crisis?

continued

From the policyholder's perspective, it gives new meaning to the familiar admonition of "buyer beware." Everyone wants a bargain, but in the world of insurance, a bargain may prove to be costly.

Actually, this is a very complex situation and the solution will be equally complex. Tort reform is absolutely necessary and appropriate. Greater public understanding of the dangers in liability must increase, as in physicians' awareness of potential malpractice situations.

At PICO, we see our job as maintaining required protection for our policyholders at realistic rates. One thing we are sure about, Ohio physicians are safe with the OSMA Group professional liability plan, and with PICO, and they will have occurrence coverage. **OSMA**

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Mistakes to Avoid When Investing

By John E. Sestina
SMB Financial Planning, Inc.

Everyone is anxious to succeed in their investing. There are some mistakes and risks however that cannot be avoided, such as market risks and timing risks to consider. But the most common mistakes are those which investors know about and can avoid. If you will, investors seem to be their own worst enemy. The following is a list of things you should consider in your investment management.

1. The most common mistake is that investors do not install a long-term investment plan. Or worse than that, if they have a plan, they don't stick with it. Everything you buy today should be for a reason and a purpose. Often times people acquire investments that have no meaning to their long-term investment plan. When you make a purchase decision, please be sure that you consider your real objectives. It may be a good investment but still may be inappropriate to meet your objectives. Spend time determining what kind of investments best suit your goals. Determine what you are trying to accomplish. Once you activate your plan, don't falter. Give your investments a chance to prove themselves. A real estate investment might take three to five years to develop. That is both good and bad. But it is not likely you can evaluate how successful it is until after that time period.

2. Many make the mistake of overdiversifying. They buy more investments than they can properly manage. In the stock market, for example, they may buy fifty different stocks. Even mutual fund portfolios limit how many they can manage. A small portfolio of $25,000 should be limited to about five or six different stocks.

3. Investors also make the mistake of underdiversifying — putting all their eggs in one basket. You may purchase a stock, real estate, etc., but every investment has its bad times when investors lose money. Don't concentrate on one industry. Plan for modest diversification. This especially applies to people who have just a few thousand dollars to invest.

4. Investors often want to commit all their excess funds for investment purposes. They fail to keep a savings reserve on hand. The only way to know how much you will need is to actually calculate it. You might want to keep 25% to 50% of your discretionary cash in a flexible reserve. Don't tie up all your funds in investments.

5. Investors tend to speculate. You have worked hard for your savings. Don't trade in and out of an investment. Unless you really know what moves to make, chances are you probably are not going to do well. Most investors seem to lose in trading an account. There is a cost associated with getting in and out of investments and these costs tend to reduce the chances for your success. Don't be impulsive. Don't speculate — INVEST!

6. Investors don't like to admit they have made mistakes! People tend to say, "I will sell that stock as soon as it gets back to the price I paid for it." They forget that the objective is to continuously make a profit. If it takes this stock a year to get back to

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Clearly, these are two insurance coverages members should look into:

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Mistakes to avoid

continued

your purchase price, you have lost money, not gained money. So be ready to admit your investment mistakes. Don't be emotional — don't hang onto something just because you think you love it.

7. Investors fail to do their homework. The SEC requires that any new investment have a prospectus. But how many investors actually study them? Don't just rely on the information fed to you by sales persons. If you don't understand the terminology in the prospectus or how to analyze the balance sheet, consult your broker or simply go to a basic investment book that will help you understand the terms.

8. Investors love a bargain! They love to buy a piece of undervalued property. But the market place is generally very reliable. If a property is low in value, there is generally a reason. I have a saying, "If it looks too good to be true — it probably is!" Be aware of the current market, what is selling, what is going up.

9. Investors are often asked to buy fads. Remember hula-hoops, disco lessons, video game rooms, etc.? Watch out for companies that deal in fad products. Fads come and go. The objective of investing is to continuously earn profit on your investment. Fads are often stagnant after a period of time.

10. Don't forget about your investments! The days are gone when you could purchase something and sit back and wait for it to go up. It is important to review your portfolio regularly and eliminate items that are not doing well. Part of the review should include a goal as to when you are going to sell the property or stock. For example, you may say that when the stock goes up 20% you will sell it, or if it drops 10% you will sell it. However, once it gets to the 20% there is often a strong tendency to hold onto it. Do not fall into the trap of a gambler who continues to bet and eventually loses his winnings.

The most difficult part of investing for any individual is keeping what he has already earned. Preservation of principal continues to be the most important part of managing a person's portfolio. **OSMA**

John E. Sestina holds the professional designations of Certified Financial Planner (CFP) and Chartered Financial Consultant (ChFC). He is a member of the Institute of Certified Financial Planners, the International Association for Financial Planning, and is among the select group of professional financial planners to be admitted to The Registry of Financial Planning Practitioners. He is currently Board Chairman of the National Association of Personal Financial Advisors, and is a vice-president with SMB Financial Planning, a member of the PICO Financial Services Group which provides specialized financial planning services to physicians and other professional individuals and corporations.

Obituaries

ANDREW CARR, MD, Dayton; Meharry Medical College, Nashville, TN, 1956, age 57; died May 11, 1986; member OSMA.

BEN McCOLLAM, MD, Toledo; Ohio State University College of Medicine, 1936; age 73; died April 9, 1986; member OSMA and AMA.

PAUL DOBSON, MD, Youngstown; Medical College of Wisconsin, Milwaukee, WI, 1948; age 62; died April 24, 1986; member OSMA and AMA.

FOOK LIM DONG, MD, Ashtabula; Ohio State University College of Medicine, 1959; age 53; died April 5, 1986; member OSMA and AMA.

WALDEMAR KARNAS, MD, Dayton; Akademia Medyczna, Krakow, Poland, 1953; age 56, died May 8, 1986; member OSMA.

WILLIAM S. SKARYD, MD, Elyria; Case Western Reserve University School of Medicine, 1941; age 69; died April 22, 1986; member OSMA and AMA.

FERNARDO M. VARGAS, MD, Medina; Faculty of Medicine and Surgery University of Santo Tomas, Manila, 1956; age 55; died March 8, 1986; member OSMA and AMA.

JOSEPH EDWARD WOLF, MD, Lyndhurst; Case Western Reserve University School of Medicine, 1946; age 67; died April 25, 1986; member OSMA.

Essay

What Is a Doctor?

By Elizabeth A. Mercer

(Contributed by Jack Sullivan, MD)

Between high school graduation and the AMA there are those individuals who aspire to become Doctors. They come in various shapes, sizes and colors. They are many things to many people — sometimes a cross between a father confessor and a St. Bernard. However, they have at least two things in common: a love for mankind and the poorest handwriting anyone ever tried to decipher.

In their formative years they probably watched bugs, played with worms, and carried toads home in their pockets. They asked so many questions that their parents were tempted to send them back or sell them to the highest bidder. But very soon their curiosity became productive and they set a specific goal and thus they became Doctors.

Patients love them, children tolerate them, nurses obey them, their spouses put up with them and their children would like to see them.

A Doctor is someone who is on the golf course, gone fishing, at a convention, in an airplane or any other inaccessible place when you really want them, and always on their day out when you get sick!

They are expected to be on call 24 hours a day, never need sleep, rest on the way to the hospital, always answer the telephone on the second ring and never ever go on vacation. They should be able to diagnose your illness over the phone and call in a prescription that will cure you in three hours!

They receive you into their presence with a cheerful greeting, a big smile on their face, and ask "How are you today?" Now, I ask you, would you be there if you were a well person? I'm always tempted to say, "I'm just fine, I came to see how you are!" (No extra charge.)

A Doctor is superman in a white coat, compassion with a stethoscope, love with a thermometer and courage with the results of your test in his folder.

A Doctor is superman in a white coat, compassion with a stethoscope, love with a thermometer and courage with the results of your test in his folder.

I believe the term charisma was coined by Doctors to describe Doctors, and talk about loyalty! They stick together like a litter of new born pups. If you don't believe this, just try to get one of them to admit that the colleague who referred you to them was anything but a genius!

Doctors come into this world naked just like you and I, but somewhere between puberty and Social Security they become a breed apart. Some of them drive sports cars (for a quick getaway) and some of them wear funny hats. And have you ever noticed how they develop little quirks? While they are examining you they shake their head and sigh! They do this so that when they give you the news, no matter what it is, you are immediately happy that it wasn't any worse! They conduct their consultations over liver and onions in the hospital cafeteria and thus decide your fate! If they tell you what you want to hear, they are compassionate, caring individuals; but if not, they are ignorant, you most certainly want a second opinion, and they no doubt received their diploma from a mail order catalogue!

But who else would leave a t-bone to meet you at the office with a sick child? Who else would leave a party to check on your sick mother? Who else would miss their child's graduation to ensure that you are well enough to attend yours? Who else will offer comfort at the bedside of a loved one when they feel like crying themselves?

Who else forgives you all your idiosyncrasies and treats you anyway? Who else can you meet socially who will look you straight in the eye and never by the flicker of an eyelash allow the world to know that he knows all your guilty little secrets? Who else but your Doctor!

Regardless of the above, they are a much respected and very valuable addition to any community, and those of us who have one are thankful beyond degree. So let us remember and give thanks for the courageous men and women who spent innumerable years in preparation and training, sacrificed their salad days in study, and dedicated their lives to the improvement and preservation of life — *that we might have life and have it more abundantly! These are doctors.*

Elizabeth A. Mercer is a patient of Jack Sullivan, MD, of South Charleston, Ohio.

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Gastric Bubble Therapy of Obesity

By Helmut Schreiber, MD
Daniel P. Guyton, MD

Obesity has finally gained its rightful place in the long list of diseases which afflict mankind. The National Institutes of Health Consensus Development Conference held in February 1985 clearly details the health implications of body weight which is in excess of 20% above ideal, as defined by standard height/weight tables. The 26-year follow-up of the participants in the Framingham heart study group has, likewise, shown that obesity is an *independent* health risk which deserves treatment as aggressively as any other chronic disease.

As is the case with many other forms of chronic illness, the treatment modalities for obesity have been less than satisfactory. The main reason for lack of success with conventional forms of diet therapy for obesity is the result of the multifactorial nature of its etiology. Thermodynamic studies have clearly demonstrated that caloric intake in excess of caloric utilization is responsible for most forms of obesity. This simplistic explanation, however, fails to take into account the psycho-social and environmental elements which are responsible for the overutilization of calories in our westernized society. Most diet programs offer a sensible combination of caloric restriction, behavior modification and exercise in an attempt to control this highly addictive type of chronic illness. A high rate of recidivism among patients with extreme degrees of obesity, however, accounts for the low success rate with these conventional forms of treatment. As a result, more drastic forms of treatment have been utilized in our desperation to treat severe obesity.

Best known among the aggressive forms of obesity treatment are starvation or semistarvation diets, liquid protein diets, intestinal bypass surgery (no longer commonly used), jaw wiring, and the current stomach restrictive operations (stomach stapling), of which two have "stood the test of time" (gastric bypass and vertical banded gastroplasty [VBG]). Recently, the gastric balloon or bubble, another form of therapy for obesity, has been approved for use in this country by the Food and Drug Administration (FDA). This device was developed by Drs. Lloyd and Mary Garren and the American Edwards Laboratories. While it was tested in the laboratory and in controlled clinical trials for almost two years, FDA restrictions on its continuous use are outlined below.

Description and indications for use

The gastric bubble is made of an elastomeric plastic and is cylindrically shaped with a hollow central channel. It is a medical device indicated for use as a *temporary adjunct* to diet and behavior modification therapy to reduce weight of those individuals who failed to reduce their weight with those measures alone. Patients must be at least 20% above ideal weight and the expected benefits of the therapy should be greater than the risks of the procedure. The mechanism of action is poorly understood, but it is believed to suppress appetite between meals by fundic stimulation, thus effecting feedback inhibition of central appetite control centers. The bubble occupies approximately 25% of the normal gastric capacity and therefore induces early satiety and fullness.

How is the gastric bubble inserted and used?

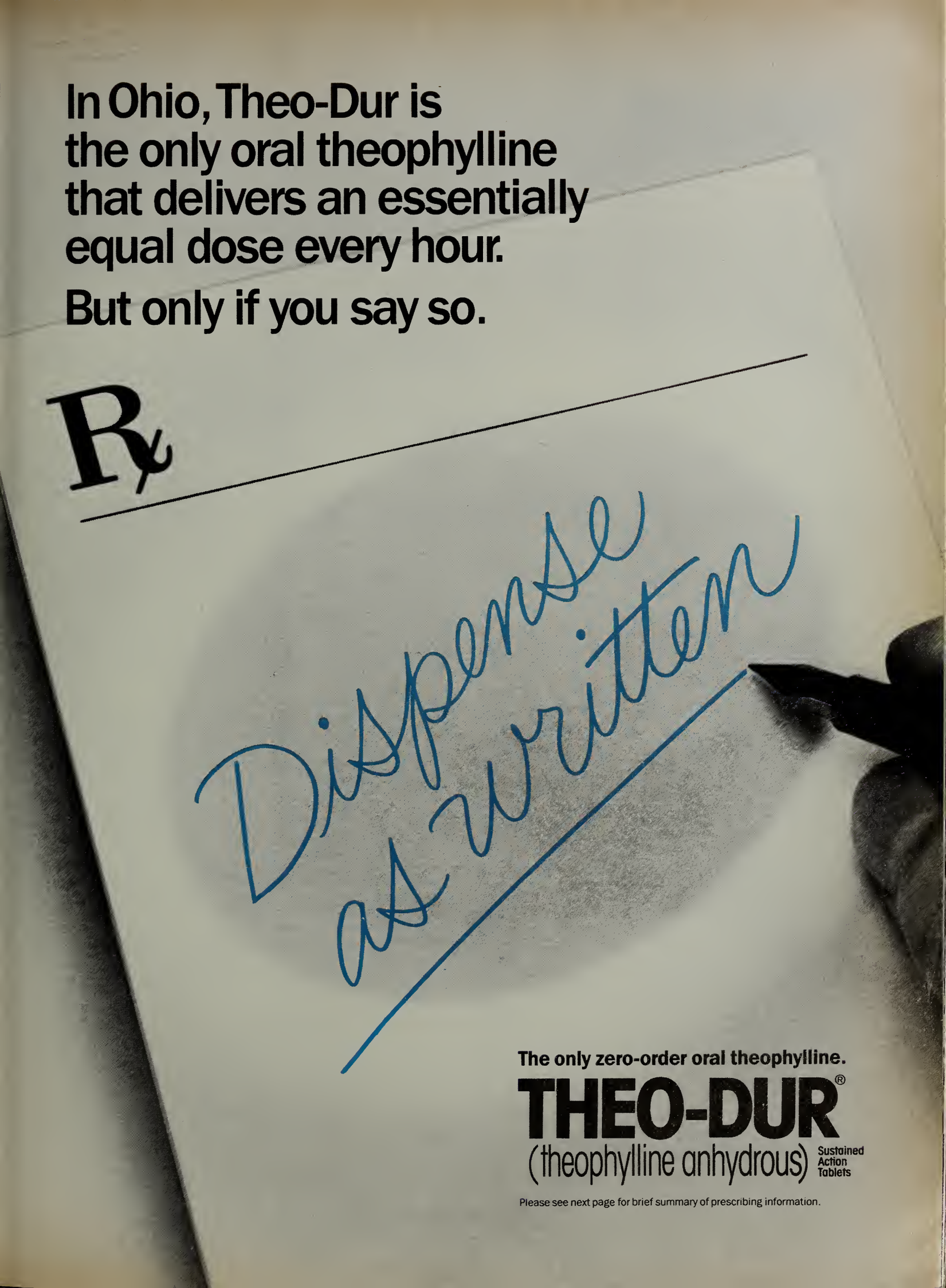
After a routine physical and laboratory screening, the device is implanted per orum by licensed physicians duly trained and skilled in interventional gastrointestinal endoscopy who have mastered the skill of preparation of the balloon prior to implantation. This latter skill can be learned through attendance at one of the seminars sponsored by American Edwards Laboratories. The bubble implantation takes place under light sedation and topical pharyngeal anesthesia. After a routine screening esophagogastroscopy, a clear plastic tube carrying a deflated bubble in its tip is introduced into the stomach. Using a small catheter attached to a one-way valve in the balloon, the endoscopist inflates the balloon with 200-210 cc of air with a syringe. When properly inflated, the balloon ejects itself from the tip of the tube and is allowed to remain in the stomach while the carrier tube is withdrawn. The stomach is once again reinspected for proper inflation and position of the device. The entire procedure takes between 20-30 minutes from start to finish.

Following implantation, the patient is instructed to remain on a liquid diet for one week and to avoid gastric stimulants such as coffee, tobacco, aspirin and alcohol. Post-insertion patients are placed on a multi-vitamin and mineral supplement, a bulk-forming agent and an antacid to be taken between meals and at bedtime. After the initial one-week liquid diet, an 800-1000 calorie diet is recommended and continued until the desired weight is lost. During the entire insertion period (4 months), the patients must attend weekly diet and behavior modification sessions, and an exercise program is highly encouraged.

The device should normally be removed endoscopically after

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Indications: THEO-DUR is indicated for relief and/or prevention of symptoms of bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.
Contraindications: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the tablet components.
Warnings: Excessive theophylline doses may be associated with toxicity; serum theophylline levels should be monitored to insure maximum benefit with minimum risk. Incidence of toxicity increases at serum levels greater than 20 mcg/ml. High blood levels of theophylline resulting from conventional doses are correlated with clinical manifestation of toxicity in: patients with lowered body plasma clearances, patients with liver dysfunction or chronic obstructive lung disease, and patients who are older than 55 years of age, particularly males. There are often no early signs of less serious theophylline toxicity such as nausea and restlessness, which may occur in up to 50% of patients prior to onset of convulsions. Ventricular arrhythmias or seizures may be the first signs of toxicity. Many patients who have higher theophylline levels exhibit tachycardia. Theophylline products may worsen pre-existing arrhythmias.
Precautions: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.
Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hourly or sometimes 8 hourly intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.
Usage in Pregnancy: Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.
Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthines to a mother who is nursing, taking into account the risk-benefit of this therapy.
Pediatric Use: Safety and effectiveness of THEO-DUR administered every 24 hours in children under 12 years of age, and every 12 hours in children under 6 years of age, have not been established.
Adverse Reactions: The most consistent adverse reactions are usually due to overdose and are:
Gastrointestinal: nausea, vomiting, epigastric pain, hematemesis, diarrhea.
Central nervous system: headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.
Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias.
Respiratory: tachypnea.
Renal: albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis.
Others: rash, hyperglycemia and inappropriate ADH syndrome.
How Supplied: THEO-DUR 100 mg, 200 mg and 300 mg sustained action tablets are available in bottles of 100, 500, 1000 and 5000, and in unit dose packages of 100.
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Gastric Bubble Therapy

continued

four months. A new one may be implanted if further therapy is needed. No data is available regarding safety and effectiveness of the device beyond ten months of continuous therapy. Once removed, the patient should be encouraged to remain on the same prescribed diet and to continue practicing the modified eating behavior which was used during therapy. Follow-up by the primary physician is highly desirable for continued success with the balloon therapy for obesity.

Contraindications and precautions

The gastric bubble should not be used in patients who have not exhausted more conventional forms of dieting and behavior modification. It should be avoided in patients who have peptic or gastric ulcer disease, large hiatus hernias, previous history of gastric or bowel surgery, and patients who take anticoagulants and antiarthritic medications. It should, likewise, be avoided in patients who would not tolerate the stresses of routine upper gastrointestinal endoscopy. Since success is dependent on the patient's adherence to the strict dietary restrictions, bubble therapy should be discouraged in patients with a strong history of non-compliance with other dieting methods.

Complications and adverse reactions

Abdominal cramping and/or nausea may occur and generally subsides after several days. Most patients do not experience any sensation of the bubble and may engage in any form of physical activity and may travel safely in commercial airplanes.

Complications which occurred during clinical investigations include a device deflation rate prior to three months of approximately 10%. This is associated with symptoms of return of hunger and/or modest weight regain. Gastric ulcers were recorded in 1.6% and one case of pyloric obstruction secondary to a deflated device occurred, requiring endoscopic removal. One case of intestinal obstruction occurred in one patient who has had previous small bowel resection which required surgical removal of the bubble. Other potential theoretical complications are perforations of the upper gastrointestinal tract (esophagus, stomach) during placement which may require emergency surgery, hemorrhage related to the procedure, and those complications related to routine gastroscopy.

How effective is stomach bubble therapy?

Since this form of therapy has not been in wide use for a long period of time, only the results of the clinical trials conducted on about 100 patients are available for evaluation. European experience with balloon therapy for obesity supports the effectiveness of this mode of therapy and is similar to the results of the brief clinical trials in this country. More data will no doubt follow since the approval of the device for general use a few months ago. (See Figs. 1, 2.)

During the study period, nine of 13 patients went off antihypertensive medication, 10 patients had normalization of elevated fasting blood sugars, five of seven patients had significant decrease in serum triglycerides, three patients lost enough weight

to expedite elective surgery, and patients invariably had a sense of general well-being.

How does balloon therapy differ from stomach stapling?

Our own brief clinical experience with about 30 balloon implantations, and a much greater experience with about 300 gastric stapling procedures (Vertical Banded Gastroplasties), indicates that major differences between these two forms of obesity treatment are becoming clearly apparent. (See Fig. 3.)

*Since stomach stapling procedures have been used clinically for many years, results have been much more predictable, especially with the current versions of Vertical Banded Gastroplasty and Gastric Bypass. Weight loss is usually quite dramatic and for five years, quite stable. Whether these encouraging results with stomach stapling will continue is not known. Results with balloon therapy are too premature at this time, but cautious optimism exists regarding its role in the overall management of resistant forms of obesity. More experience will be required before its role in our armamentarium against obesity is established. Due to the relatively low risk associated with its use, it should be seriously considered as a means of therapy before resorting to surgery.

It is our belief and prediction that balloon therapy for obesity will prove beneficial for lesser degrees of obesity, i.e. 20% to 100% overweight, and for well motivated individuals in excess of 100% above ideal body weight. Due to the "morbid" nature of obesity and eating behavior patterns of those more than 100% over ideal weight, however, stomach stapling will remain a more effective and predictable form of therapy despite its greater risk. Newer generations of gastric balloons capable of remaining in place for much longer periods of time, now under investigation, may eventually rival the results achieved with surgery in patients with extreme forms of obesity.

Dr. Helmut Schreiber is the chairman of the Department of Surgery at Huron Road Hospital, Cleveland, and assistant clinical professor of surgery at CWRU School of Medicine. Dr. Daniel P. Guyton is the assistant chairman of the Department of Surgery at Huron Road Hospital and assistant professor of surgery for NEOUCOM.

Figure 1

SELF-EVALUATION OF PATIENTS DURING CLINICAL TRIALS

	YES	NO
Was insertion of bubble comfortable?	85%	15%
Was implant comfortable while in place?	95%	5%
Did implant decrease appetite?	97.5%	2.5%
Has weight loss been easier than before?	92%	8%

Figure 2

CUMULATIVE WEIGHT CHANGE WITH BUBBLE THERAPY

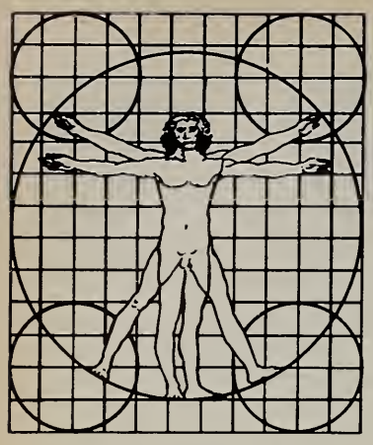
At six months:	Pounds	% Ideal Body Weight
Mean	-41	-31%
Minimum	-11	-10%
Maximum	-75	-68%

Mean weight loss at 10 months: -76.5 pounds

Figure 3

HOW DOES BALLOON THERAPY DIFFER FROM STOMACH STAPLING?

	STOMACH STAPLING (VBG)	BALLOON THERAPY
Length of Treatment	Permanent	Temporary
Risk	Major Surgery	Low
Ability to overeat solids	No	Yes
Ability to abuse snacks/ liquids	Yes	Yes
Clear sign if patient overeats	Yes	No
Must be on a special diet	Yes	No (Low calorie)
Must be at least 100 lbs. overweight to have procedure	Yes	No
Long-term results with weight loss	Unknown*	Unknown*



CLINICAL & SCIENTIFIC

PEPTIC ULCER UPDATE

James H. Caldwell, MD

The therapeutic advances of the past decade have enhanced our understanding of the natural history of peptic ulcer disease. For example, efficacy studies of cimetidine led to the first data on the placebo response and a new appreciation of recurrence rates after healing. In addition, a new picture of peptic ulcer disease as a disorder of great economic importance has emerged, with the annual cost in the United States estimated to be four billion dollars. We will survey the present state of understanding of the natural history of peptic ulcer, review the concept of cytoprotection and its implications for therapy, and outline the presently available alternatives in medical therapy.

Epidemiology and Pathogenesis

Hospital admission rates during the seventies suggested that peptic ulcer disease was declining in frequency. On the contrary, newer studies of incidence and prevalence suggest that while admissions for uncomplicated ulcer have declined, the total number of cases remains relatively constant. Incidence rates (new cases/year/100 persons) in the United States were 0.3 in 1968 and 0.29 in 1975, or about 350,000 new cases of peptic ulcer annually. The one-year prevalence (total cases) for the same population has been 1.7 to 1.9% for more than 20 years, which means that more than four million Americans experience peptic ulcer at some time during a single year. The lifetime attack rate for ulcers in the United States and several other Western populations ranges from 5 to 10%. While the male to female ratio was 2:1 in 1961, it is currently nearly 1:1 in the United States, so that individuals of both sexes have about one chance in ten of having ulcer disease in their lifetimes. The relative prevalence of duodenal to gastric ulcer remains 4-5:1. Mortality rates for both duodenal and gastric ulcer have fallen by two-thirds since 1962, from 3.1 and 3.5/100,000 persons to 0.9 and 1.1 respectively.

In spite of the popular belief among lay persons that "stress" is a major cause of ulcers, especially duodenal ulcers, there is little supporting evidence. Most reviews of the subject conclude that inadequate attention has been given in the past to other known ulcerogenic factors, or that symptoms were equated with established peptic ulcer disease. In fact, older studies often failed to distinguish periods of symptomatic activity in patients with preexisting ulcer from the new onset of symptoms in formerly well individuals. It seems reasonable to accept that psychological distress may heighten symptoms or precipitate an attack in a person constitutionally susceptible to ulcer, but that this is not synonymous with causing the problem.

Some environmental and genetic factors are etiologically important. A major influence on the initiation and persistence of ulcer is cigarette smoking. Smokers have twice the incidence of ulcer that nonsmokers do, smoking impairs healing during therapy, and those who smoke during attempts at ulcer prophylaxis have higher recurrence rates than nonsmokers. Although smoking does not alter the basal gastric secretion of acid, smoking promotes duodenal-gastric reflux, impairs pancreatic secretion of bicarbonate in response to duodenal acidification, and inhibits the reduction of acid secretion produced by H_2-receptor antagonists. Thus, a history of cigarette smoking is a crucial part of the data collection on patients with both duodenal and gastric ulcer disease.

The use of anti-inflammatory drugs is another important influence on the natural history of peptic ulcer, especially gastric ulcer. There is a significant association of aspirin use with gastric ulcer and upper gastrointestinal hemorrhage. Aspirin produces a dose-related disruption of the gastric mucosal barrier to diffusion of the hydrogen ion and inhibits the production of certain prostaglandins by the gastric mucosa. Both phenomena are associated with mucosal injury; whether the barrier function of the mucosa is prostaglandin-dependent is not yet known. Endoscopic studies of normal volunteers show that some are at risk from ordinary doses of aspirin, with lesions ranging from superficial mucosal erosions to large ulcers after 5 days of aspirin ingestion. Many such lesions produce few symptoms, but increase the chance of mucosal blood loss. Thus, while gastric intolerance to aspirin is characteristic of many hypersecreting, dyspeptic persons, these symptoms are not reliable for accurate diagnosis or for screening those at risk of serious mucosal disease.

Nonsteroidal anti-inflammatory drugs (NSAID) other than aspirin are widely used and are promoted as safer than aspirin for the gastric mucosa. Nonetheless, both gastrointestinal bleeding and gastrointestinal symptoms are common limiting factors

James H. Caldwell, MD, is a professor of medicine in the Division of Gastroenterology at The Ohio State University College of Medicine in Columbus, Ohio.

in the clinical use of NSAID. While current literature suggests the ulcer risk from these agents is unproved, endoscopic data and clinical experience indicate that many of these agents have a potential similar to that of aspirin for gastric mucosal injury. The cautious physician will warn patients of this possibility, observe patients using NSAID for occult bleeding, and avoid its use in patients with histories of prior aspirin intolerance, peptic ulcer disease, or unexplained gastrointestinal bleeding.

The risk of corticosteroid therapy is clearer. About a decade ago, an influential article challenged the widely accepted association. Reviewing published data, the authors concluded that there was no evidence of a role for steroids in ulcerogenesis, with the possible exception of high-dose and/or prolonged therapy. However, a more recent reexamination of pooled data concluded that there was, in fact, a significant association between corticosteroids and ulcer. Authoritative reviewers have pointed out that, although the data are statistically significant, the size of the increase in ulcer disease associated with the use of steroids is very small (about 1%). Corticosteroids are responsible for far less ulcer disease than aspirin or NSAID.

The contribution of genetic factors to the pathogenesis of peptic ulcer is well established. Both gastric and duodenal ulcers occur two to three times more often in first-degree relatives of patients with ulcer than they do in others. The most important familial component of ulcer disease is hyperpepsinogenemia I, an autosomal dominant trait found in as many as 50% of patients with duodenal ulcer. Recent evidence shows that possession of this phenotype confers a substantially greater risk of ulcer than that found in those with normal serum levels of pepsinogen I.

Cytoprotection

During most of this century, speculations on the etiology of peptic ulcers suggested that there is an imbalance between "aggressive" factors (such as acid, pepsin, bile salts) and "defensive" factors. Until recently, little was known of mechanisms of mucosal defense, for most research dealt with abnormalities of acid secretion. It is now clear that mucosal defense is the net effect of several activities. One of these is the secretion of mucosal bicarbonate by both gastric and duodenal epithelium that is prostaglandin-dependent and that produces an unstirred water layer of high pH immediately adjacent to the cell surface. A seemingly paradoxical observation is that mucosal defense is linked to hydrogen ion secretion and mucosal energy metabolism so that actively acid-secreting gastric mucosa is more resistant to injury than is resting mucosa.

This phenomenon of mucosal "cytoprotection" has received the greatest attention among recently identified components of the gastric mucosal defense system. Cytoprotection describes the dramatic protective effects of certain prostaglandins on gastric mucosa exposed to a number of mucosa-injuring agents, including boiling water, exogenous acids, and absolute ethanol. Protection due to prostaglandins of the E series is independent of acid inhibition and is apparently a direct effect on gastric mucosa. The protective effects of exogenous prostaglandin are reproduced by stimulation of endogenous prostaglandin synthesis. Conversely, the noxious effects of mucosa-injuring treatments are exaggerated by simultaneous inhibition of prostaglandin synthesis, presumably accounting for some of the toxic effects of NSAID on the gastric mucosa. The therapeutic implications of investigations into cytoprotection are reviewed in the following section.

Treatment: Past, Present, and Future

Ten years ago, our only choices for medical therapy of peptic ulcer were: diet, a tradition with no scientific basis; antacids, symptomatically effective but not proven to accelerate healing; and anticholinergic agents, rational but never proven effective. Today, treatment is based on sound pharmacologic data. First, antacids were established as effective, but only in doses that most patients will not tolerate for long. Second, H_2-receptor antagonists have become enormously popular (a second generation is already available). Third, sucralfate, an agent with proven mucosal protective properties, has been thoroughly studied and is gaining a place in therapy.

H_2-receptor antagonism is based on the observation that antiallergic antihistamines do not inhibit gastric acid secretion. The existence of a second class of receptors was established by the development of histamine analogs with acid-inhibiting properties. Cimetidine, the first to be commercially available in the United States, is now established as effective for short-term treatment of both duodenal and gastric ulcer. Healing rates in excess of 80% are seen after four to eight weeks of treatment with the recommended dose of 300 mg q.i.d. Recent studies suggest that 400 mg b.i.d. is equally effective. Prophylactic use of 400 mg q.h.s. for a year significantly reduces the incidence of recurrent ulcer while patients remain on therapy, in contrast to relapse rates of 50-75% in untreated patients. Today, the decision for remission-maintaining treatment depends on a compromise between the risks of long-term treatment and the clinician's estimate of the likelihood and severity of relapse. Although there are safety considerations in long-term therapy, these are not apparent in statistical comparisons, for the total number of adverse events during a year of nightly cimetidine is not greater than that in a control population. Still, there is a potential for gynecomastia and other antiandrogenic effects in males during long-term use. Patients should be kept under surveillance for these and other less common side effects, including various CNS manifestations in the elderly and in those with kidney or liver disease, who may develop high blood levels of the drug. Both short- and long-term use may produce undesirable drug interactions, most notably an enhanced effect of coumadin, propranolol and other beta-blockers, theophylline, lidocaine, diazepam, and anticonvulsants. Other side effects, such as hemodynamic or cardiac rhythm disturbances, liver or renal injury, skin rash, bone marrow suppression, myalgias, and other isolated events are rare.

The currently popular alternative H_2-receptor antagonist is ranitidine, a structurally related compound with some different properties. The most advantageous of these is a greater molar potency, on the order of four to eight times greater than that of cimetidine. The clinical result is that duodenal ulcer healing rates with 150 mg b.i.d. are identical to those in patients treated with fourfold higher doses of cimetidine. Most comparative studies have not shown that ranitidine produces higher healing rates than cimetidine, although uncontrolled observations suggest that patients who fail therapy with cimetidine may benefit from a switch to ranitidine. It is possible that some apparent differences between drug potency may be due to host factors such as smoking or compliance. The major advantage of choosing ranitidine appears to be a lower incidence of drug interaction. Ranitidine does not enhance the effect of drugs dependent on hepatic metabolism. Similarly, ranitidine has less potential for CNS and anti-androgenic effects, although reports of such

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Colleagues In The News

Edited by Deborah Athy

JAMES E. BARNES, MD, of the Ohio State University College of Medicine, has been appointed to the Ohio State Medical Board by Governor Richard F. Celeste.

ROBERT S. DANIELS, MD, Cincinnati, has been selected to serve on the Governor's Task Force on Black and Minority Health. Dr. Daniels is the dean of the College of Medicine and a professor of psychiatry at the University of Cincinnati Medical Center.

ALFRED DEMARIA, MD, of Riverside Hospital in Columbus, has been elected chairman of the professional advisory board of the Epilepsy Association of Central Ohio.

HERBERT C. FLESSA, MD, FACP, professor of medicine in the division of hematology-oncology at the University of Cincinnati Medical Center, has received a three-year appointment to the Commission on Cancer of the American College of Surgeons.

F. MILES FLICKINGER, MD, of Lima, has received a Distinguished Service Award for his contributions to the Lima campus of the Ohio State University.

MAX E. GRIFFIN, MD, director of the Ambulatory Pediatric Medicine at Children's Hospital Medical Center of Akron, has received the Pediatric Recognition Award for his outstanding contributions to the health and welfare of children in Ohio.

ROBERT GULMI, MD, a pediatrician from Akron, has been elected treasurer of the Ohio Chapter of the American Academy of Pediatrics.

D. ROSS IRONS, MD, 11th District Councilor for the OSMA, has received a Distinguished Service Award from the Bellevue Area Chamber of Commerce for his contributions to Bellevue Hospital.

WILLIAM J. KENNEDY, MD, of Newark, is the 1986 recipient of the Arthur Dobkin MD Fellowship. Dr. Kennedy is the chief of Addictive Services at Licking Memorial Hospital.

MAURICE D. KOGUT, MD, vice president for medical affairs at The Children's Medical Center in Dayton, has been appointed to a four-year term on the National Board of Medical Examiners.

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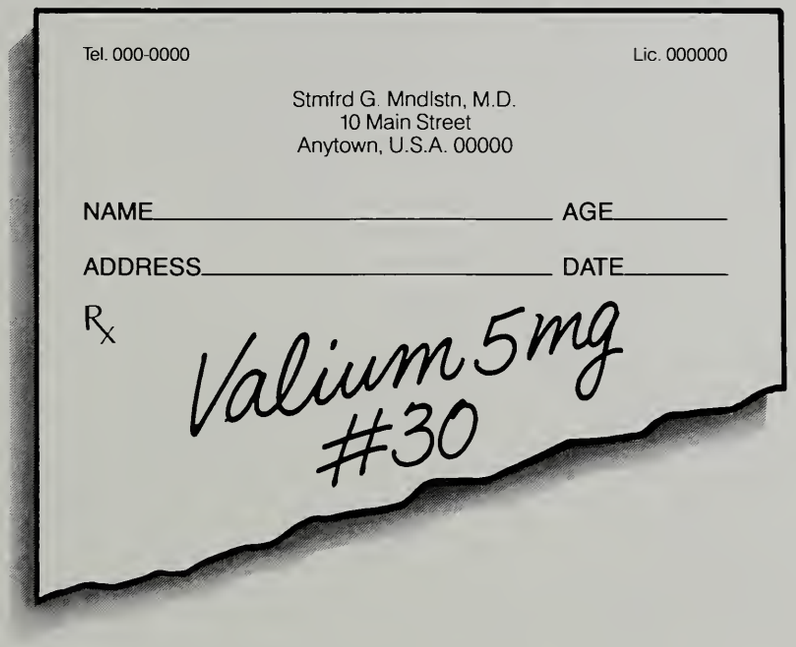
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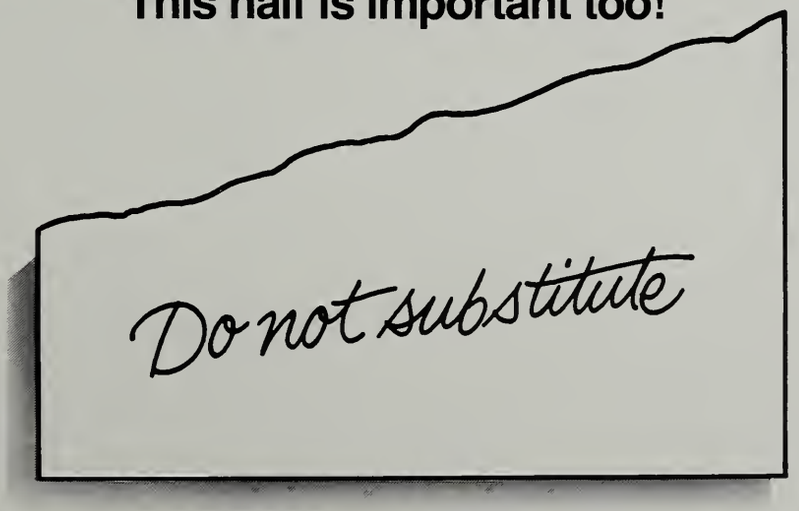
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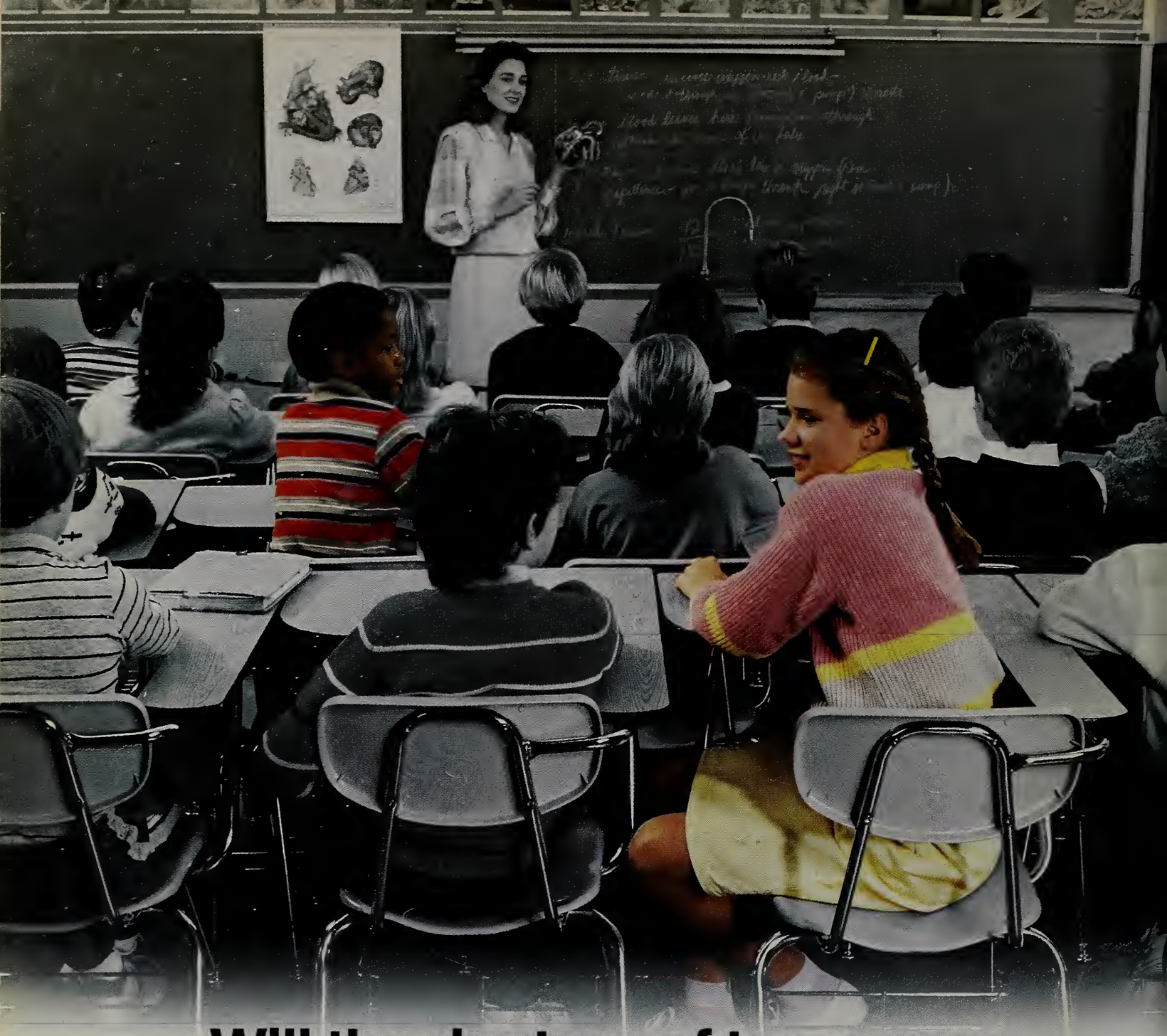


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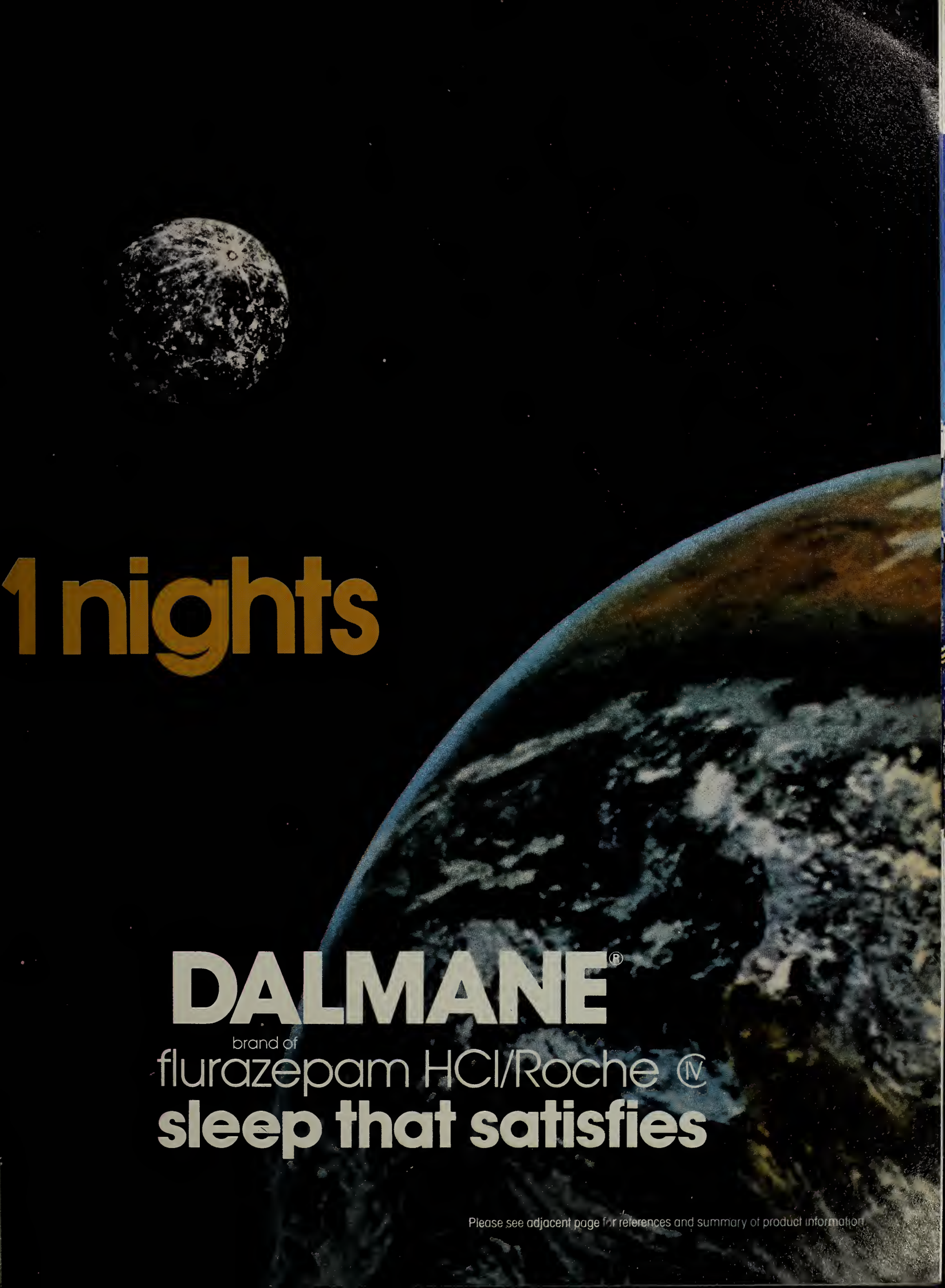
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FROM THE EDITOR

And now, for some good news...

In years past, the *Journal* has presented numerous stories and even two issues which have focused on the subject of chemical addiction. With this issue, however, we present some good news along with the bad — for although you will be reading about some of the newer abuse substances in an article by Rootstown psychiatrist A. James Giannini, MD, and his colleagues; about the children of alcoholic parents in an article by Cincinnati psychiatrist Charles Enzer, MD; and my own article about the increasing number of gambling addicts in this state, there is also an article by William Kennedy, MD, about medicine's newest specialty — addictionology — and the hope for higher success rates in the future treatment of chemically addicted patients. His "Second Opinion" explains how the specialty evolved, the need for it, and some predictions about its future. Along these same, more optimistic lines, Associate Editor Susan Porter has written a story on the primary care physician's role in the treatment of dependencies. Information for the article came from a scientific section meeting held by the psychiatric association during this year's OSMA Annual Meeting, and seems to be especially timely, in light of a recent *JAMA* article which states that primary care physicians are apt to misdiagnose — and sometimes not even recognize — their chemically addictive patients.

You will not find anything in this issue, however, about impaired professionals — although the problem of chemically addicted physicians has not gone away. Instead, we have opted to hold this story for our next issue, which will focus on the health of the medical family.

In unrelated matters this month — be sure to read this month's collections of stories in our Ohio Medi-Scene section. Jack Cairns, a communications specialist at the Medical College of Ohio at Toledo, has written about the lure of small-town practices. You will also find a fascinating story about in-flight emergencies and the latest information on "Treating the Anguish of AIDS."

AIDS also figures into our "Clinical Update," a procedural guide for testing AIDS patients, contributed by the Ohio Department of Health.

Now, if ever there was a need for some *good* news . . .

Karen S. Edwards

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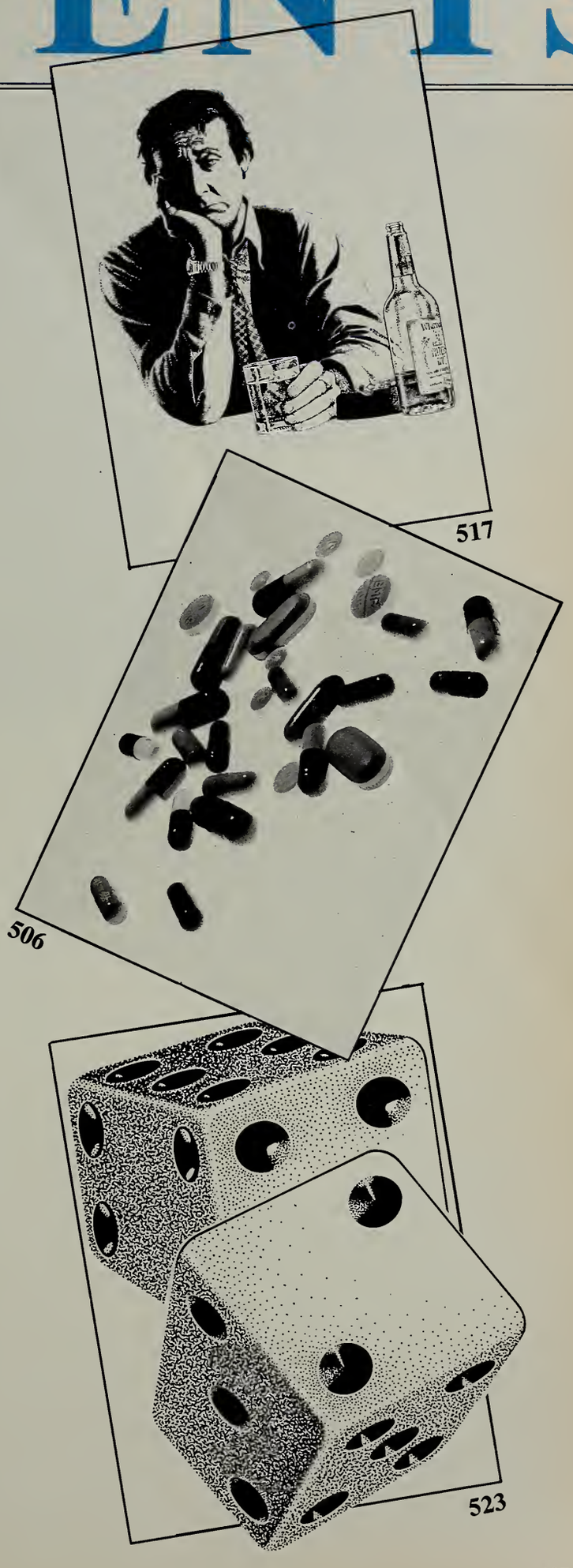
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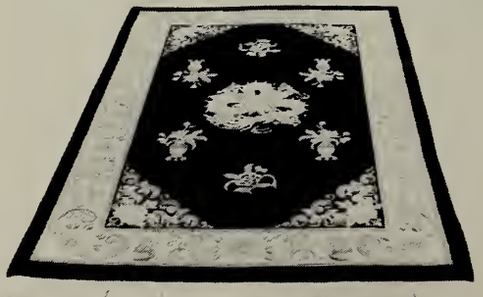
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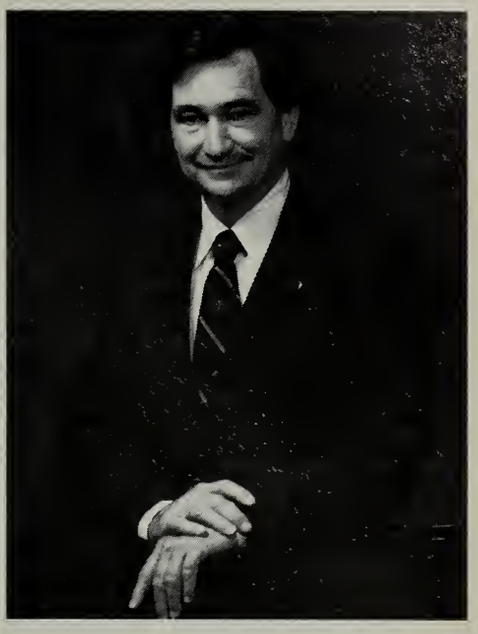
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Quality of Care — Quantity of Care



By John E. Albers, MD

Quality of medical care is extremely difficult to accurately define, because it has multiple interpretations to multiple physicians. Where one physician may see quality, another may see under-utilization. I believe that all physicians know what quality of care is when they are involved with their patients and when doing their own particular chart reviews. It is only when one starts to do peer review on others that the quality of care becomes more indefinable and tenuous in regards to its total meaning.

With all the inroads that have been made into the practice of medicine, along with the industrialization of medicine, there has been more and more media hype on the quality of care. Everyone seems to use the term "quality of care" and use it to their own advantage, whether it be the government with Medicare or Medicaid, HMOs, IPAs, PPOs or within quality assurance committees. It is my belief that the physician, and the physician alone, is the one who can best judge this quality of care. It cannot, nor should it be, judged by non-physicians!

With the industrialization of medicine and government intervention, I believe that a new phrase has come into being: "quantity of medical care." Some people like to relate quantity of care with quality of care. These two may well be related, but not necessarily so. In reference to quantity of care, it is important to refresh our minds with a little bit of the history that has taken place since the intervention of the third-party system. Prior to third-party involvement in health care, the physician and the patient did not want to have their care in the hospital unless absolutely necessary, and the connotation of going to the hospital was as a place to die. This belief was bred out of the fact that people were admitted to the hospital in the end stages of disease and, of course, the modern modalities of treatment and diagnosis were not available, and a good percentage of people who were admitted to hospitals did not improve.

With the intervention of the third-party payors, immediately the hospital became a popular place for patients to be diagnosed and treated. In fact, the third-party payors would not permit outpatient payments, and all services to be covered by insurance had to be provided within the hospital setting. Our patients at that time pressured us to admit them for simple diagnostic procedures that would well have been performed in an outpatient setting, only because their insurance would pay for it if they were hospitalized. The physician, being compassionate and understanding, has to yield to this pressure, although, at the same time, physician groups and organized medicine were trying to convince the third-party payors that outpatient benefits should be covered and should be broad so that the appropriate care of the patient could be done in the appropriate setting. This philosophy existed for several decades and this was ingrained into our patients, as well as into the physician, as the best method of giving quality care, and, with this, the quantity of care increased. Like any other system in which the individual believes that he is not directly paying for what he utilizes, abuses were bound to become apparent.

Now with the crunch of budgeting restrictions by the government, and with the cost of care being far beyond its expectations, the emphasis has gone the opposite way toward non-admissions to hospitals, with increased diagnostic and therapeutic modalities being done as an outpatient. This has also made its mark through the HMOs, IPAs and PPOs that are sprouting up around our state and across the country. As the for-profit entrepreneurs have entered medicine, additional pressure has been put on physicians to limit their quantity of care and not to sacrifice their quality of care. The quality of care can be kept at its highest level with some limitations on the quantity of care. There is no doubt about that. I think that every one of us as physicians has recognized this and has seen its results when we have been able to cooperate and coordinate the therapeutic and diagnostic modalities that are necessary to give good quality care to our patients.

Each of us as a member of a noble profession, which must be morally and ethically above reproach, has to accept the responsibility of quality of care without abusing the quantity of care. **OSMA**

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Addictionology: Why Medicine Needs This Newest Specialty

By William J. Kennedy, MD



This spring, four subcommittees of the American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD) met in different locations across the country to review applicants who want to sit at the October credentialing examination. Approximately 800 physicians are in the field of chemical dependency. This should not be interpreted as a board certification identifying expertise, but as only one of the preliminary steps in that process. In 1987 those who wish to sit for this examination will have more stringent requirements as far as experience and training are concerned, and eventually the fellowship training will be required to be affiliated with an accredited medical school.

This process has developed over the last four years, first with the founding of the American Academy of Addictionology by Dr. Douglous Talbott. This began as a rallying point for those who supported the medical specialty of addictionology and as a spur for others to examine the need for a specialty in chemical dependency. One of the results was the Kroc Ranch conferences of February and October 1983. These brought together all of the diverse elements in the field of alcohol and drug treatment such as self-help groups, research, government, addictionologists, and psychiatrists to share their concerns about the direction that the field of chemical dependency was taking. The first conference dealt with what was to be the appropriate role of medicine in this field. It was the conclusion of the participants that medicine had an important and appropriate role to play and this could best be performed by an identifiable medical specialty. The second conference dealt largely with the issues of how and when the process of certification could best be accomplished. The American Medical Society on Alcoholism (AMSA) had been around for many years and had established a reputation in research and education and was well known for its high quality leadership. AMSA accepted the charge of putting this process in motion. Some of us who had participated from the onset with the American Academy of Addictionology and the Kroc Ranch conferences became the nucleus for the AMSA committee on credentialing.

Those of us who work as full-time physicians in the field of chemical dependency are acutely aware of the need for medical leadership in many areas. Too often the physician rubber stamps programs that have too much interest in profits and too little concern for treatment. Our concerns also extend to the field of medical education where house staff and students are frequently misinformed or have limited access to adequate educational materials. This is reflected by the failure of physicians to diagnose chemical dependency and/or to route their patients to appropriate care. A recent poll by the AMA indicates that the majority of practicing physicians continue to see chemical dependency as a psychiatric disorder or moral problem rather than a primary disease. This is in contrast to the general public who now see alcoholism as a primary

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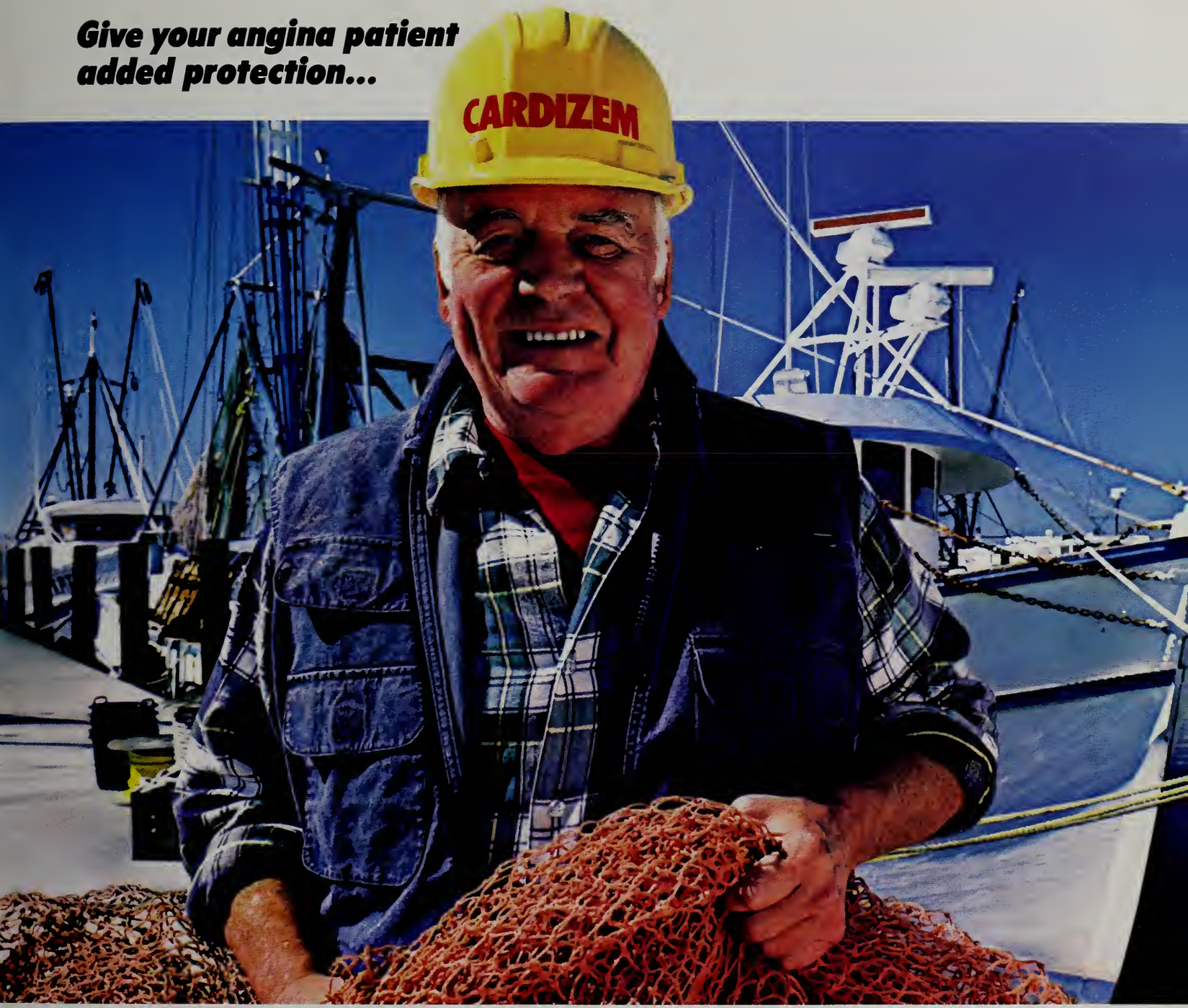
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CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).
WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV nodal refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). An acute study of oral diltiazem in patients with impaired ventricular function (ejection fraction 24% ± 6%) showed improvement in indices of ventricular function without significant decrease in contractile function (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is limited. Caution should be exercised when using the drug in such patients.*
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 11/85*

See complete Professional Use Information before prescribing.

References: ***1.*** *Frishman WH, Charlap S, Goldberger J, et al: Comparison of diltiazem and nifedipine for both angina pectoris and systemic hypertension. Am J Cardiol 1985;56:41H-46H.* ***2.*** *Weiner DA, McCabe CH, Cutler SS, et al: The efficacy and safety of high-dose verapamil and diltiazem in the long-term treatment of stable exertional angina. Clin Cardiol 1985;7:648-653.* ***3.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983;106(6):1341-1347.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *McCall D, Walsh RA, Frahlich ED, et al: Calcium entry blocking drugs: Mechanisms of action, experimental studies and clinical uses. Curr Probl Cardiol 1985;10(8):6-80.* ***6.*** *Chaffman M, Brogden RN: Diltiazem: A review of its pharmacological properties and therapeutic efficacy. Drugs 1985;29:387-454.* ***7.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50 (Sept):94-116.* ***8.*** *Shapira W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984;24(Dec):150-159.* ***9.*** *Johnston DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687.*

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disease. We are not only not taking a leadership role, we are not even in step with the changing attitudes of the public, courts and industry. The courts, legislators, and licensing boards also have need for experts to turn to. The treatment field has evolved with a variety of treatment modalities, but some are supported by a very meager data base of treatment outcome. Today we should not expect third parties to pay for outdated treatment, but we continue to accept a variety of treatment approaches that have little to support them other than their tradition. Treatment outcome studies need to be based on hard data such as length of sobriety and not immeasurables such as quality of life. Today every other area of medicine must address the issues of cost effectiveness and so should we.

All of these issues are important, but in my perspective the single overriding issue is something quite different. Alcoholism and drug addiction continue to have the stigma that used to be associated with cancer and tuberculosis. The destigmatization of the disease of chemical dependency is extremely important. At the present time those ill with chemical dependency only accept treatment when they are threatened by the loss of their family, their freedom, their livelihood, or their lives. This is a disease of denial. With effective leadership we should be able to change that. We know that treatment early in the course of the disease is most effective and less expensive to the individual and the community. These are the appropriate roles for addictionologists. **OSMA**

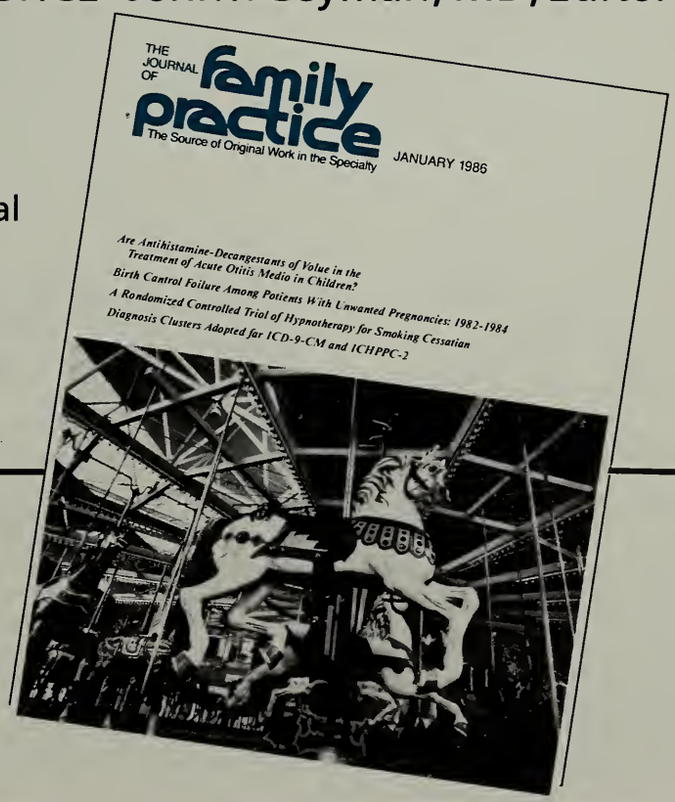
William J. Kennedy, MD, is the Program Director of Shepherd Hill Hospital in Newark, Ohio.

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OSMA NEWS

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Allergy relief

Of the approximately 40 million people in the U.S. who cope with hay fever and similar allergies, about one-third would rather tolerate allergy symptoms such as "constant runny noses, sneezing and stuffed-up heads," than the drowsiness incurred by most allergy medication, according to the results of a survey reported in a recent issue of *US Medicine.*

However, an antihistamine has recently been approved by the Food and Drug Administration which could spell relief for allergy sufferers — without the typical sleepiness associated with most anti-allergy medication.

According to a U.S. Department of Health and Human Services press release, the new product is *terfenadine,* which will be selling under the trade name Seldane.

This may cheer up the 75 percent who reported in the survey that they refrain from taking allergy medication, even when they're experiencing allergy symptoms, in order to avoid the medication's hazy effects.

Contributions wanted

If you have an opinion you'd like to voice, an idea to share, some news to report, we'd like to hear from you. Contact the Executive Editor, the Ohio State Medical Journal, 600 S. High St., Columbus, Ohio 43215.

Are cancer patients *really* living longer?

Cancer survival rates are not improving as much as the public has been led to believe, say Alan Fisher, MD, and Wendy Worth, MD, in a recent issue of *ACSH News & Views.*

The interpretation of survival statistics for cancers of the lung, breast, colon, and prostate — the most serious and widespread forms of cancer — is highly controversial, and, according to Dr. Fisher and Dr. Worth, sometimes suspect.

"Cancer survival rates are generally reported in terms of the percentage of victims who live for at least five years after their disease is diagnosed. Early diagnosis turns the clock back and the patient appears to live longer," they explain.

"If cancer organizations were to give out information seriously questioning improvements in cancer survival, they would lose public confidence and contributions. People do not like to give money to a sinking ship, but they do like to contribute to a worthwhile endeavor," Worth continues.

While Drs. Fisher and Worth do attest that there have been approvements in the treatment of cancers such as Hodgkin's Disease and leukemia, they continue to push for a more "objective" view of survival rates for other kinds of cancer.

Keeping an eye on home health care

If some of your patients are interested in home blood pressure measurement devices, consider some of the following findings from a new report by the National High Blood Pressure Education Program.

- Nonelectric mercury and aneroid home blood pressure measurement devices that are used in conjunction with a standard stethoscope are considered reasonably accurate.
- Electronic home blood pressure monitors are considered sufficiently accurate for home use in most instances, if patients and health care professionals are aware of the potential problems involved in their use.
- The reliability of stationary or coin-operated devices is considered limited. Users of these devices are encouraged to seek professional advice before taking any action as a result of a blood pressure reading on one of these machines.
- Ambulatory monitoring systems are still considered investigational as their clinical usefulness remains undetermined. These systems are recommended for use in a selected number of patients only.

In addition, the report recommends that health care professionals instruct patients in measurement, calibration and record-taking techniques, as well as assist in the selection of accurate equipment.

Edited by Deborah Athy

Tune in to your patients



More than half of all patients with alcohol abuse, other drug abuse or mental problems obtain their medical care from primary care physicians, most of whom fail to diagnose, treat or refer such patients properly, says a recent report in the *Journal of the American Medical Association (JAMA).*

As many as 19 percent of the United States adult population (almost 30 billion people) suffer from substance abuse or mental disorders, says Douglas B. Kamerow, MD, of the National Institute of Mental Health (NIMH), and colleagues. Costs of these conditions (including direct costs of treatment and support as well as indirect costs such as productivity loss) reached nearly $218 billion in 1983, the researchers say. They estimate that more than 108,000 deaths each year result from substance abuse and mental disorders.

The study found that nearly 70 percent of persons affected by one of these conditions sought some form of medical care during the previous six months, while only one-fifth stated they made a visit for mental health purposes. "A great potential exists in primary care for prevention, detection, treatment and referral of these patients," the researchers say. "Primary care physicians, however, have not been very successful at diagnosing and treating substance abuse and mental disorders because of inadequate training, patients' attitudes and the constraints of the health care system."

When money talks, who listens?



When it comes down to it, almost nothing has the immediate appeal of money.

A recent study by the Metropolitan Life Insurance company has found that most patients would change physicians if it meant saving money.

The insurance company arrived at this conclusion by examining its preferred provider organization, which the study says offers financial incentives for patients if they reexamine their selection of doctors and hospitals.

"Patients will migrate with incentives," the report claims — and those incentives, translated into English, almost always equal dollars.

China needs surplus medical books

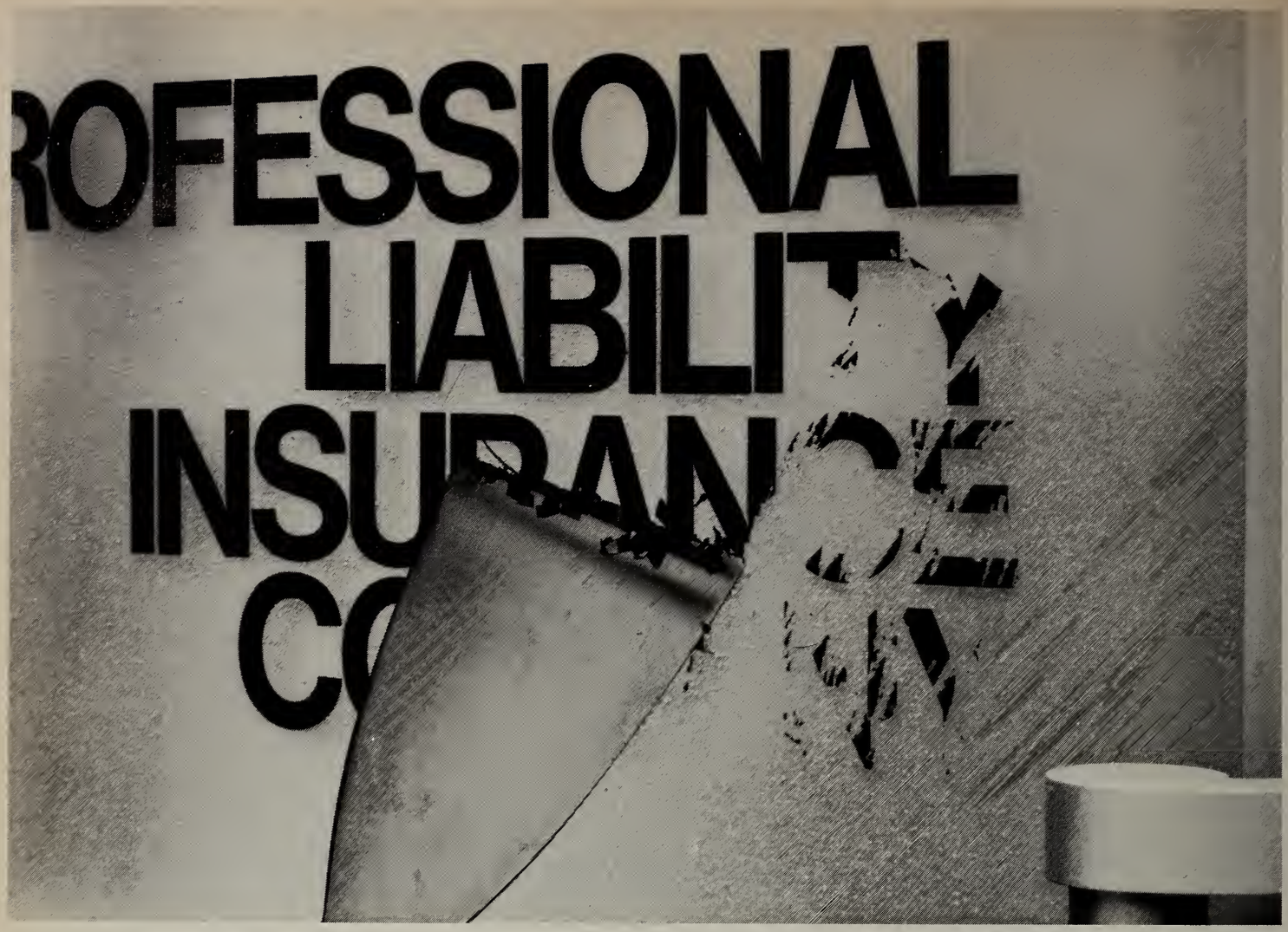
A California physician, Jordan M. Phillips, MD, has recently created a non-profit corporation, "Medical Books for China," which actively solicits medical materials — such as books, journals, audio tapes, films and slide lectures — for Chinese physicians.

China's collection of western medical literature was destroyed during the reign of the Red Guards, who, in an effort to stamp out all western culture, destroyed libraries, burning the western books they contained.

For the past seven years, Dr. Phillips has arranged for approximately 700,000 medical books, journals and other material to be sent to Chinese doctors. The Chinese government has established a distribution committee headed by the Health Bureau and the Medical School at Tianjin, which is responsible for overseeing fair distribution. Freight costs from California are paid by the Chinese government, and shipment from Tianjin is borne by the doctors and medical institutions which order materials.

Dr. Phillips is appealing for additional support from the U.S. medical community for more books, journals and teaching materials. However, medical books should not be older than 1960, and journals no older than 1969. Donations are 100 percent tax deductible at current market value. Shipments should be sent to:

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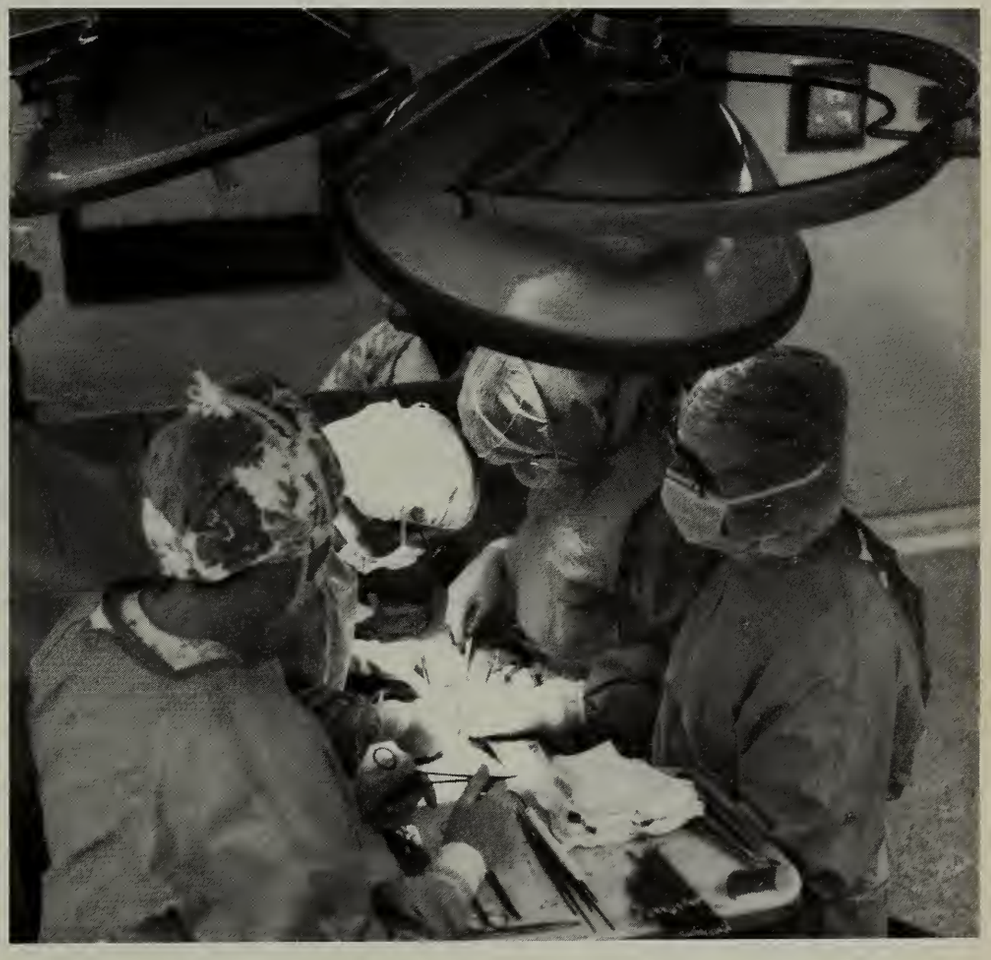
an update on organ transplants . . . treating AIDS anguish . . . HEARTSMART education . . . the lure of small-town practice . . . in-flight emergencies . . .

Ohio organ transplants — an update

Physicians need to overcome their reluctance to ask the families of dying patients to permit organ donations, J. Wesley Alexander, MD, told fellow physicians and others attending the first professional meeting of the Ohio Solid Organ Transplantation Consortium last April.

This failure to mention the organ donation option is one of the main reasons why Ohio and the rest of the country continue to face critical shortages in the procurement of organs, he and others stated at the conference held at Children's Hospital Medical Center in Cincinnati.

Since the consortium was founded in July of 1984, over 70 solid organ transplants have taken place at the five member hospitals: Children's Hospital Medical Center in Cincinnati, the University of Cincinnati Medical Center, the Ohio State University Hospitals of Columbus, the Cleveland Clinic Foundation and the University Hospitals of Cleveland.



The purpose of the consortium is to pool the state's efforts to procure organs and to ensure they go to the proper patients.

The purpose of the consortium is to pool the state's efforts to procure organs and to ensure they go to the proper patients. Patients are evaluated by medical criteria only — not by their ability to pay, social worth factors, race or sex. The consortium has a patient selection committee to review each case.

This centralized effort at obtaining, distributing and transplanting organs also helps to keep costs down by avoiding duplication of services throughout the state. While a kidney transplant now costs between $30,000 and $40,000, a heart transplant generally runs between $100,000 and $120,000, and liver transplants are the most expensive of all: $135,000 to $250,000. Funds come from Medicare, Medicaid and private insurance companies.

The consortium — the only one

OHIO MEDI-SCENE

Organ transplants update . . . continued

of its kind in the country — also helps to finance the transplant program for those underinsured or unable to pay. Physicians in the consortium donate 25 percent of their professional fees to this "cushion fund," while hospitals give one-quarter of all transplant-related institutional gifts for this relief effort. Funds for the consortium also come from the foundations in each of Ohio's three major cities.

The number one problem with the transplant program is organ shortage.

To date, the Cleveland Clinic leads the state in the number of heart transplants performed in Ohio — 30, as of the April meeting. The two Cincinnati hospitals had performed nine heart transplants as of that date, and the University Hospitals of Cleveland, one. OSU Hospitals in Columbus announced that it will begin a heart transplant program this summer.

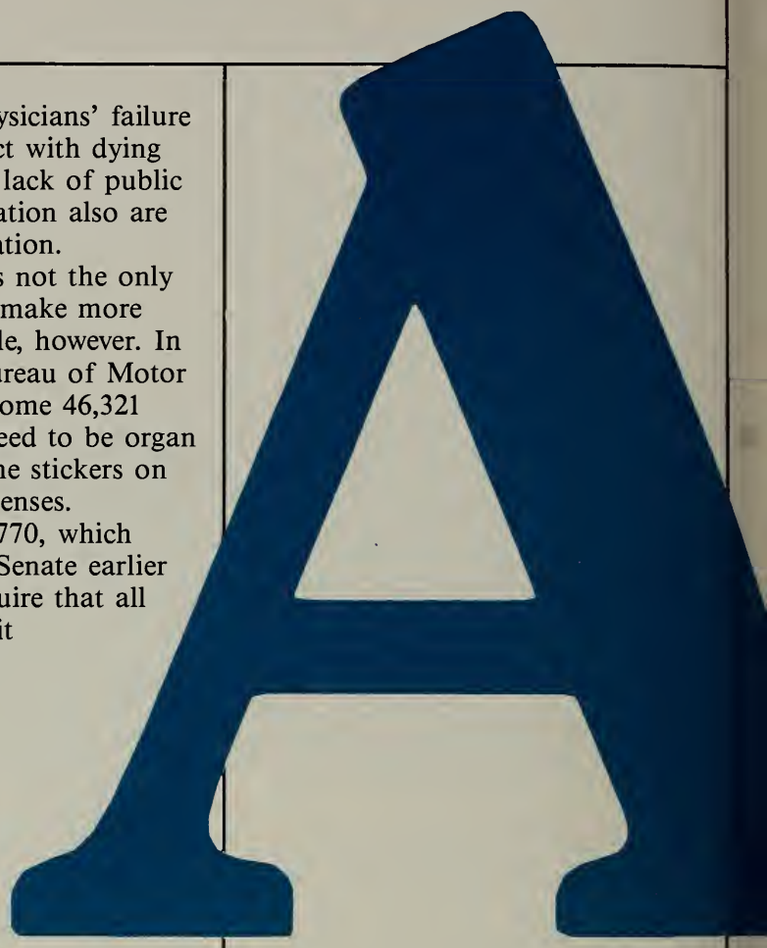
OSU, on the other hand, is a national leader in kidney transplants; it ranks 70 in the nation for the number of these performed. Liver and pancreas transplants also have taken place at OSU.

The number one problem with the transplant program continues to be the shortage of organs. Nationwide, 10,000 await kidneys, 300-400, hearts, and an equal number are awaiting livers. Some 130 individuals are currently awaiting kidneys at OSU Hospitals alone.

In addition to physicians' failure to broach the subject with dying patients' families, a lack of public awareness and education also are blamed for the situation.

The consortium is not the only body attempting to make more solid organs available, however. In March, the Ohio Bureau of Motor Vehicles signed up some 46,321 individuals who agreed to be organ donors by signing the stickers on the back of their licenses.

Also, House Bill 770, which passed in the Ohio Senate earlier this year, would require that all Ohio hospitals solicit donations in cases of brain death. — *Susan Porter*



Treating AIDS anguish

The prognosis is bad — the patient is going to die, most likely within months. To make matters worse, his family has disowned him, his boss has fired him and his friends avoid him like the plague.

AIDS is much more than the Human T-Cell Leukemia Virus (HTLV) that attacks the body's immune system, leaving it helpless against a variety of opportunistic infections that lead to death. AIDS is also a social and psychological nightmare, especially for the homosexual patient who may already be suffering from personal and family problems related to his sexual identity and unconventional lifestyle.

"AIDS — a national scourge and the 'Scarlet A' of our era — is the biggest killer of men between the ages of 25 and 40 in New York City," says Jeffrey C. Hutzler, MD, a psychiatrist at the Cleveland Clinic who helped form a task force to deal with AIDS patients there. Yet AIDS is more than a fatal disease, Dr. Hutzler told members of the Ohio Psychiatric Association and the OSMA Section on Psychiatry at the OSMA's 1986 Annual Meeting. "It touches on every aspect of being a human being."

Most terminal patients rely heavily on the support of family and friends to help them get through their final days, Dr. Hutzler says. But more likely than not, the homosexual AIDS patient is alone in the world, dependent on gay support groups, sympathetic clergy, and caring medical personnel for their last kind words. And even these may

be in short supply, says Dr. Hutzler. "AIDS patients die more lonely than most people," he says.

Even hemophiliacs who contact AIDS have special psychological problems, says Dr. Hutzler. "They generally have been overprotected as children. Their parents were afraid to let them go outside because they worried about them bleeding."

Thus, while not suffering from the "homophobia" which isolates homosexual AIDS patients, hemophiliacs, too, have a difficult time coping with strange surroundings and procedures of the hospital, along with the fears and prejudices of the public.

In addition, the AIDS virus has been shown to have a definite neurological impact on the patient's brain — "95 percent of AIDS patients show signs of neurological disease," says Dr. Hutzler. Symptoms include clumsiness, falls, spasticity, and even encephalitis, along with headaches, dementia and an inability to concentrate. Thus, mentally, AIDS patients are not fully equipped to deal with the barrage of problems suddenly hurled at them.

So how does a physician help the AIDS patient get through the psychological and mental aspects of the disease as well as the physical ones?

A first step, says Dr. Hutzler, is to evaluate the individual's support system. Does he have family and/or friends willing to help care for him? Even a sympathetic and loyal companion may be put off by the constant vomiting and chronic diarrhea that beset many AIDS patients, not to mention the open sores and lesions characteristic of the infections that set in. "The TV programs don't really show how terribly sick these AIDS patients usually are," he says.

If there are family members available, it is important to determine how they are dealing with the crisis. "There are generally three ways families react when they discover a member has AIDS," says Dr. Hutzler. Those with psychological sophistication are usually able to deal with it in an open forum and are able to resolve many of the emotional difficulties that occur. Unfortunately, these families are few and far between.

In a second group of families, the status quo is maintained — relationships stay the same, as family members largely deny that the problem exists. And in a third set of cases, a further distancing results. Relationships within the family already shaky may end altogether.

Family therapy may provide some help in working through the psychological aspects of the disease. But often family members are not interested in facing these problems, and, in some cases, the AIDS patient is living far away from the family.

Thus a loyal lover or friend may be the AIDS patient's only supporter; but here, too, special problems may result. Feelings of fear, guilt and anger may hamper the relationship, and a potentially infected partner may even contemplate suicide. Couples therapy with emphasis on open communication may help the AIDS patient and his friend cope with the situation. All too often, however, the patient is completely abandoned. "Even mere acquaintances will flee him wherever he goes," says Dr. Hutzler.

Thus more often than not, the AIDS patient is left to work through the emotional stages of a terminal illness alone. Increased stress, anxiety, anger and rage are initial reactions to the diagnosis. Later, depression may set in, and as the disease progresses, physical pain may dominate.

Still, it is important that the patient accomplish a certain amount of "grief work," says Dr. Hutzler. This generally involves resolving interpersonal conflicts with family and friends — again, a difficult task — along with focusing on those things that are most important in life. Like all dying patients, the AIDS victims will generally go through a life review, expressing his regrets and making an attempt to resolve inner conflicts for the last time. It is also at this time that a sympathetic clergyman becomes invaluable, although unfortunately, "some religious clergy won't attend AIDS patients," says Dr. Hutzler.

And finally there is the need for caring and concerned medical support. AIDS patients not only require excellent medical care and a thorough discussion of the treatment options available to them, they also need a large amount of empathy, respect and kindness. "This places a tremendous emotional demand on the internal staff," Dr. Hutzler admits. But all too often, medical staff members are the dying AIDS patient's sole companions.

Also placing a lot of stress on physicians and other medical personnel are "the worried well" — the thousands of individuals who fear they may have been exposed to AIDS or that they may develop it in years to come.

Because there is an average five-year incubation period for the virus, some fear they have been infected by past encounters — particularly those who have had homosexual experiences or heterosexual experiences with prostitutes.

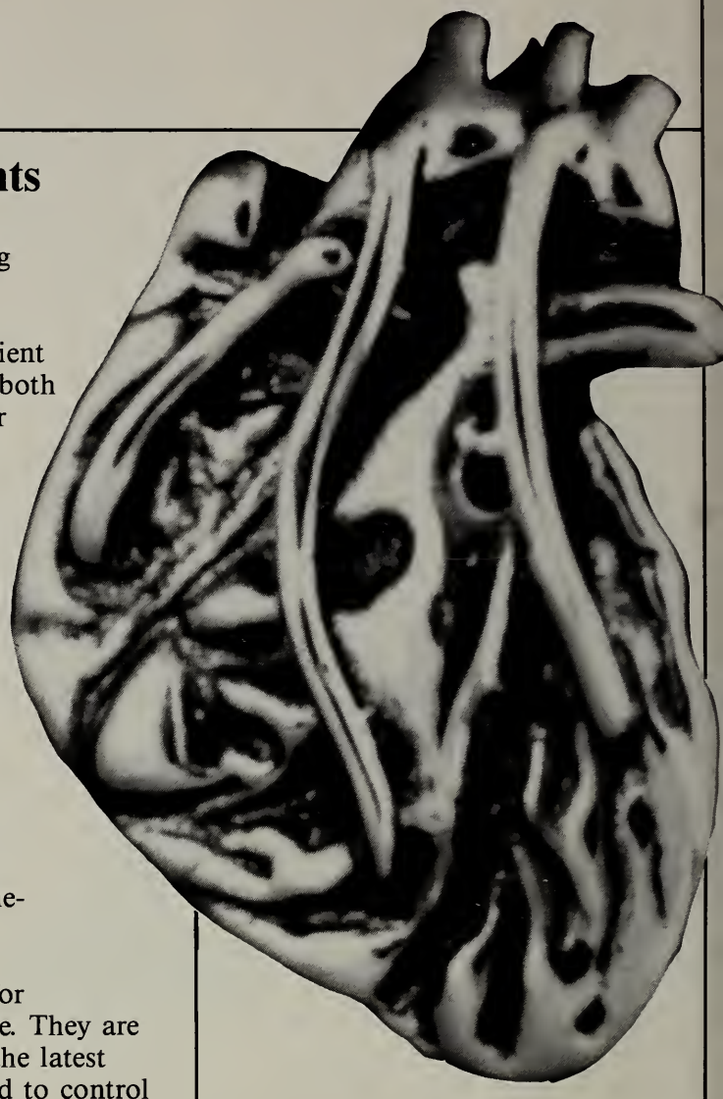
Unfounded fears can generally be eliminated with a thorough physical examination and one or two educational sessions with the personal physician. "Usually these patients will respond well to information and reassurance," says Dr. Hutzler.

Perhaps an even greater problem is the "AIDS hysteria" that has infected the country. But that, too, can be alleviated, simply by providing accurate information to the public through physicians, teachers, religious leaders and others. This is best delivered, Dr. Hutzler adds, in small groups, where questions can be thoroughly answered and concerns can be openly discussed.

Still, the anguish that accompanies AIDS is likely to last as long as the disease itself, and Dr. Hutzler sees no end in sight. Rather, he predicts, an increasing number of heterosexuals are likely to contract the disease, making it an even greater concern to health care personnel. — *Susan Porter*

OHIO MEDI-SCENE

HEARTSMART aims to educate patients



Despite tremendous advances in science and medicine concerning the causes and remedies for coronary artery disease, more Americans die from heart attacks, strokes and related disorders than almost all other causes of death combined. Why?

One reason may be that patients still don't understand how factors like cholesterol, stress, smoking, obesity, lack of exercise, etc., increase their risks of heart disease, and so they aren't truly motivated to change their lifestyles. Another is that many people remain unaware of the early warning signs of heart disease, and even fail to recognize the symptoms of a heart attack. And a third reason is that some individuals are afraid of the various diagnostic and treatment options available because they don't understand them and their benefits.

These are also the reasons why Cincinnati cardiologist Eli M. Roth, MD, and cardiac nurse Sandra Streicher spent over a year developing **HEARTSMART**, an eight-week program designed to help patients take better care of themselves and their hearts.

"There is plenty of evidence to show that decreasing risk factors can lower your risk of heart attack," says Dr. Roth. Likewise, numerous programs have been developed to deal with these various risk factors: weight loss programs, aerobic exercise classes, low-fat diets, stress management programs, blood pressure screenings, etc.

"But no one had really put it all together," Dr. Roth continues. "We were looking for an existing program for our patients — and we found a little here and a little there, but there was no comprehensive ongoing program such as **HEARTSMART**."

A well-educated patient is a healthier patient, both Dr. Roth and Streicher believe, because the proper information helps to alleviate fear and heads the patient in the right direction should a problem occur. Thus **HEARTSMART** patients banter about terms like "coronary angiogram" and "percutaneous transluminal coronary angioplasty," as they learn about state-of-the-art diagnostic procedures and treatment modalities for coronary artery disease. They are also acquainted with the latest medications being used to control and treat these conditions.

Unfortunately, many patients never bump into this kind of information until it's too late — they already have suffered an acute myocardial infarction and are on the rough road to recovery and rehabilitation. Yet many healthy individuals with a family history of heart disease are worried about their potential risk and want to know ahead of time what to expect in the way of problems — and how to prevent them, if possible.

HEARTSMART students also get a healthy dose of anatomy and physiology with the course, because it is important to understand the "why" along with the "what," Dr. Roth believes. "People need to understand that it's not magic — that there are reasons why these risk factors affect the heart in a certain way."

And they learn to apply what they learn to themselves and their lifestyles. **HEARTSMART** students have their blood pressure checked and analyzed, blood cholesterol levels drawn, and they put together a personalized program to reduce risk factors. They learn how to lower their cholesterol intake, reduce and control their weight, manage stress, stop smoking and more.

Dr. Roth and Streicher scanned hundreds of current articles, textbooks and research reports in putting together the course, and reviewed all the recommendations generated by the American Heart Association and American College of Cardiologists.

The first session of **HEARTSMART** recently took

place at our Lady of Mercy Hospital in the Cincinnati area, where Dr. Roth says participants were both interested and enthusiastic. Anyone interested in more information on the **HEARTSMART** program can write: **HEARTSMART,** 5902 Deer Run Drive, Mason, Ohio 45040, or can call Streicher at (513) 398-0982. — *Susan Porter*



The lure of the small-town practice

"Big-city medicine" is, at once, fast-paced and sophisticated, crowded and competitive — and as full as superlatives as a boy on his first fishing trip . . . the *biggest* hospitals . . . the *best* equipment . . . the *latest* research. Yet, there are thousands of physicians in this state who shy away from the metropolitan areas and practice, instead, in small, rural communities. Why? What special attraction lures them there?

That was the question the Medical College of Ohio at Toledo recently put to several of its graduates — those who have recently set up offices in some of the smaller cities, towns and villages in northwestern Ohio. The answers came quickly — without hesitation, and with a great deal of conviction.

One of them, Nicholas Walz, '37, a graduate of MCO in 1974, left a three-member family practice group in south Toledo where for three years he had been "very happy and busier than can be," to join a similar partnership in Montpelier, in western Williams County, because he "wanted to get back to the folks."

Born in Defiance, Dr. Walz says that after he went into practice in Toledo, he continued to look at small towns.

When the opportunity arose to join Dr. Robert Kanney and Dr. Clarence A. Bell, Jr., in a practice in Montpelier, 55 miles west of Toledo, Dr. Walz made the move. It was not an easy decision.

"I was set in practice, busy, involved in a residency program in Mercy Hospital. Moving to Montpelier meant beginning a practice again. There was a lot of emotional turmoil."

The hardest part of the move, however, "was leaving the patients in Toledo," Dr. Walz says.

He says that his patient population in Montpelier is different from that in Toledo. In Toledo, he explains, he saw the mother and father, both of whom worked, two children in the family, and the family had a third-party payer. In Montpelier, the patients are from all economic levels, from a company president to the tool-and-diemaker, and you follow the patient's care longer. In the smaller community, if a person breaks an arm he visits the doctor, not the hospital emergency room, so the physician does more critical care medicine.

Angela Best, MD, a native of Vaughnsville, in Putnam County, and a 1978 MCO graduate, practices psychiatry in Defiance, 40 miles southwest of Toledo, a community she says is ideal for a "family-oriented person and a pleasant place to raise children."

A solo practitioner who did "all my own billing, all my own books," in the first three years of practice, Dr. Best has an outpatient-oriented practice.

"In Defiance there is a need for me," she explains. "I see every type of psychiatric problem in persons from 3 years to 90 years, and in all types of situations."

Jonathan F. Diller, MD, a 1979 graduate of MCO who opened a solo family practice in Fremont in 1982, learned quickly, too, that Fremont needed a primary care physician. He said his practice grew so quickly he is not taking additional patients.

Born in Chicago, but reared in Convoy, in Van Wert County, where his father, Alford Diller, is a physician, Jonathan Diller refers to himself as a "small-town boy," who values smaller communities for their morals.

"I knew that I wanted to live and practice in a small community, that I wanted to go to a hospital where I could practice," he says. At Memorial Hospital of Sandusky County in Fremont he has the opportunity to provide a variety of patient services, from caring for patients in intensive care to delivering babies. He is chairman of medicine at the hospital and vice chief of staff. He also is chief of staff at St. Francis Rehabilitation Hospital and Nursing Home.

Dr. Diller says the city, the county seat of Sandusky County, 30 miles east of Toledo, offers "all the things I like to do. There is no traffic hassle, crime is low, and the schools are good." He and his wife, Karen, have a son, Andrew, 5, and daughter, Emily, 3. Just 30 minutes away at Catawba Island, Dr. Diller has a boat from which he can enjoy his main recreation, fishing.

David Houston, MD, a 1979 graduate of MCO and native of Lodi, southwest of Cleveland, practices family medicine in Pandora, 60 miles southwest of Toledo. Shortly after he began his medical training at MCO he received a grant from Bluffton Hospital to pay part of his medical training costs in return for practicing in the Bluffton area.

He lives in Bluffton, eight miles from Pandora, and enjoys the smaller communities because they are like Lodi. The small-town doctor has much to motivate him,

The patients are from all economic levels — from a company president to the tool-and-diemaker — and you follow the patient's care longer.

OHIO MEDI-SCENE

Lure of the small-town practice . . . continued

he says, explaining that, in addition to achieving his personal goals, there is great satisfaction in getting to know the townspeople in their homes, on the streets, and at high school basketball games.

Dr. Houston is in practice with two other physicians, and says he has more than enough patients, adding that the competition for patients found in larger cities is absent.

After making patient rounds each day in Bluffton Hospital between 7:30 and 8 am, Dr. Houston is available for duties at Bluffton Hospital or sees patients in the office in Pandora. He and his partners in the practice rotate on morning office hours and duty at Bluffton Hospital. He also has office hours in the afternoons, two evenings each week, and on Saturdays. The office also provides physician care for a nursing home at which 140 persons live.

Glenn Trippe, MD, 35, graduated from the Medical College of Ohio in 1976, and is the only pediatrician in Port Clinton, the county seat of Ottawa County, about 40 miles east of Toledo. He also has an office in Sandusky.

Practicing in Port Clinton as the only pediatrician means that "when a problem arrives here I have to fix it, or find someone who can," Dr. Trippe says.

Small-town medicine — like its big-city counterpart — has its own unique attractions. Where you choose to hang *your* shingle is a matter of personal choice, of course. But, at least, those choices *are* out there . . . and waiting. — *Jack Cairns, Communications Specialist, Medical College of Ohio.*

In-flight emergencies: improving the odds

Every day, one million Americans board an airplane and fly somewhere — to visit a friend, take a trip, close a business deal. They may be 90 years old, 5 months old — or any age which lies in between. They may be male or female . . . rich or, thanks to today's special super-saver deals and budget-priced airlines — even poor. And, each year, at least 21,100 of them will lose their lives in an in-flight emergency.

That figure, though staggering, is hardly surprising, says Stanley Mohler, MD, a specialist in aerospace medicine and a professor at Wright State University in Dayton. Dr. Mohler was one of several physicians addressing the subject of "High Tech Medicine" at a seminar sponsored by Wright State University, held this past May during the OSMA's Annual Meeting.

The figure did not surprise Dr. Mohler for several reasons.

Add the physical state of the passengers to the stresses that come with flying, and you have at least two reasons why approximately 232 unscheduled landings due to medical emergencies occur each year.

One reason, he says, is the physical state of the passengers themselves. People who fly are not always in the best of health. Consider that, on any given flight, there are likely to be smokers with heart conditions, diabetics, infants, handicapped persons traveling with wheelchairs and bottled oxygen, as well as the elderly.

Add to that the stresses that come with flying and you have at least two reasons why approximately 232 unscheduled landings due to medical emergencies occur each year.

"People experience a great deal of stress in airports," says Dr. Mohler. They're often rushed just getting to the airport; then, once they're there, they have to find out where they need to be and when they have to be there. If the flight is delayed — or, worse, cancelled — there is more stress, especially if the closest thing a passenger can get to a "good night's rest" is 40 winks in an airport terminal chair.

"Passengers often experience a lot of stress and fatigue before they even get on the airplane," comments Dr. Mohler.

And the risks don't end there. The drink cart that comes down the plane's narrow aisle, once the plane is in the air, is "the leading cause of injuries that take place during flight," says Dr. Mohler, adding that it's no secret flight attendants have one of the highest injury rates of any occupation.

Heart attacks, however, are at the top of most medical emergency lists — with that word "emergency" being at the very crux of the matter.

"With the oxygen pressure in most cabins, you have only four or five minutes to keep the brain tissue alive," says Dr. Mohler — and that means quick thinking and even faster action.

Until recently, however, most airplanes were not equipped to

handle anything but the most minor medical problem. For, despite the evolution of the airplane into a better, faster vehicle — capable of carrying an increasing number of people greater and greater distances — the in-flight medical emergency kit was frozen in time. It was in 1914 that Johnson and Johnson developed a "medical cabinet" to be used on airplanes — an unpretentious package, containing some bandages, a few tongue blades, a tube of burn ointment, and, until just this year, this was the *only* help available to would-be rescuers.

However, Dr. Mohler was one of a group of people who successfully effected some regulatory change in this area. As of August 1, airplanes will begin to carry more complete medical kits — similar to those that have been developed for the space shuttles. They will contain, for example, a stethoscope, sphygmometer, syringes and needles, a 60 percent dextrose solution, nitroglycerin tablets, and a basic instruction book.

Lidocaine was left out, foley catheters were left out, and something to stop labor was left out," says Dr. Mohler, although these items may show up in future kits.

In addition, Dr. Mohler has conducted some in-flight CPR workshops for pilots and hopes to conduct similar workshops soon for flight attendants. "The best place to deliver CPR is right there in the seat," says Dr. Mohler, explaining the reason for that is that timing is so critical.

"Normally, it takes one or two minutes for another passenger or the flight attendant to discover that something is wrong — another minute to call for a doctor, or to find someone else to help — and one minute for that person to get there. That four to five minute time frame you have to keep the brain alive means you have to start work the minute you reach the victim," says Dr. Mohler.

Besides, he adds, CPR in the aisle is difficult and fatiguing, and is virtually impossible for two people to do.

If the patient is sitting up in the seat, he recommends that the rescuer approach the victim from the seat behind, and press upward on the victim's stomach in a Heimlich-type maneuver. If there is time, he suggests that the victim be laid out across the seats — with the head toward the window if it is a two-seat section of the plane; toward the aisle if it is a three-seat section. This will facilitate the emergency procedures and allow two people to work more easily on the victim.

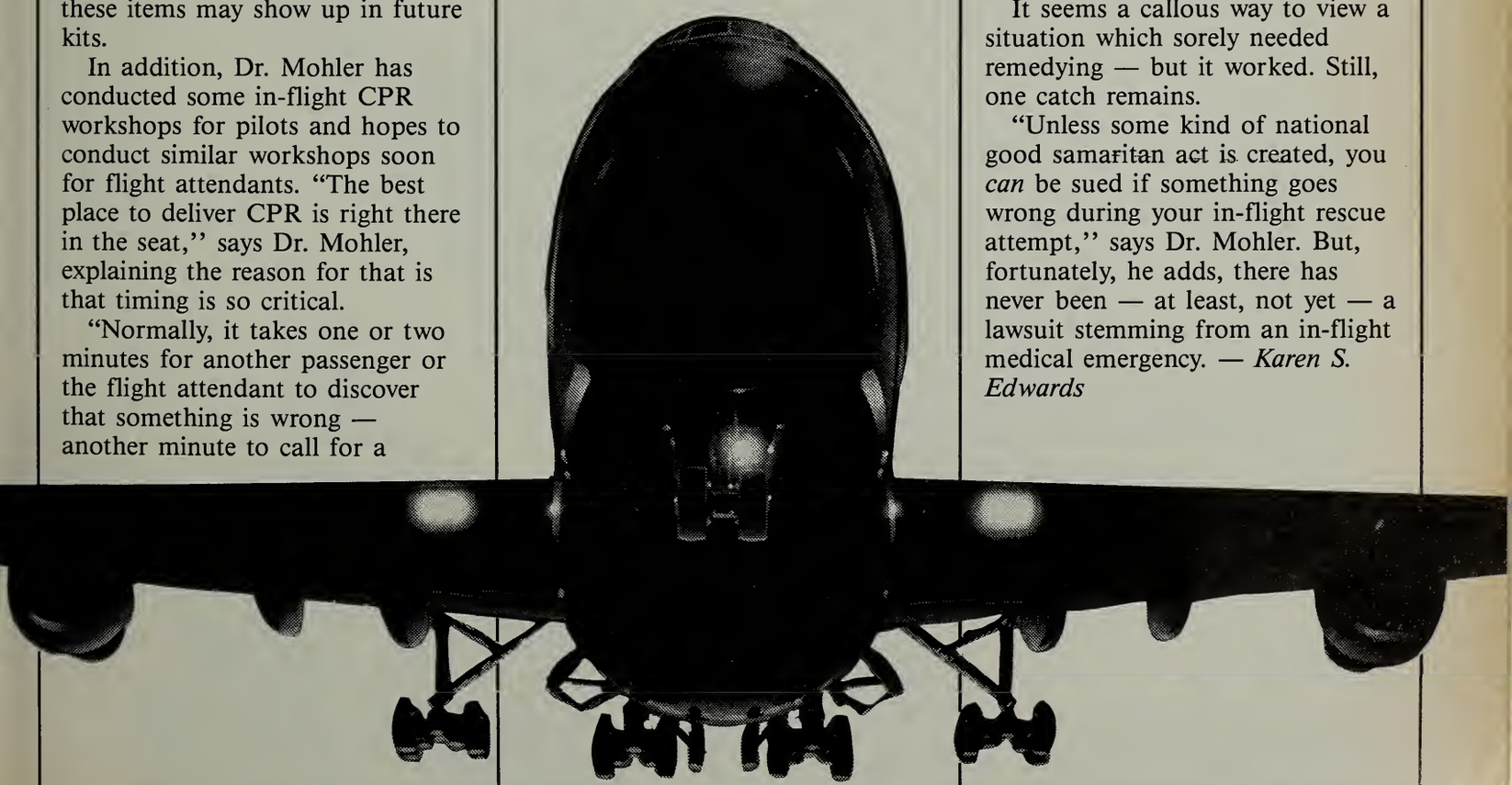
In arguing for these medical advances, Dr. Mohler says he and his colleagues were forced to explain their reasons in financial terms for the airline insurance companies.

In arguing for these medical advances, we told them that given the 1983 statistics for in-flight deaths, if 10 percent of the lives of people over 10 could be saved, a cost savings of $8.4 to $41.9 million could be realized by the airlines.

"We told them that, given the 1983 statistic for in-flight deaths, if 10 percent of the lives of people over the age of 10 could be saved, a savings ranging from $8.4 million to $41.9 million could be realized by the airlines. That's based on an insurance value of approximately $650,000 per life."

It seems a callous way to view a situation which sorely needed remedying — but it worked. Still, one catch remains.

"Unless some kind of national good samaritan act is created, you *can* be sued if something goes wrong during your in-flight rescue attempt," says Dr. Mohler. But, fortunately, he adds, there has never been — at least, not yet — a lawsuit stemming from an in-flight medical emergency. — *Karen S. Edwards*



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Contemporary Drugs of Abuse

By A. James Giannini, MD, William A. Price, MD, and Matthew C. Giannini, JD

The physician needs to know the signs, symptoms and recommended treatments of drug overdoses. Overdose of hallucinogens usually does not require drug therapy. Overdose of amphetamines ("uppers") may be complicated by the presence of PCP, a dissociative substance. It is important for the physician to be familiar with the street terminology for contemporary drugs of abuse and to be aware of how users obtain these drugs.

Drug abuse became a national problem during the 1960s, when entire subcultures developed that were centered on the use of drugs. Medical journals and lay magazines published articles on the increasing use of illicit drugs, while movies, plays and contemporary novels reflected public concern. Although drug abuse has been given less attention in the 1980s, it remains a serious problem. Recent studies indicate that drug use has increased among college and high school students in the past two decades.

Because interest in drug abuse seems to have waned in recent years, many physicians may not know the "street" terminology for contemporary drugs of abuse or the ease with which some of these drugs can be obtained. Physicians may also be unfamiliar with the signs and symptoms of drug overdose and the recommended methods of treatment. The purpose of this article is to provide information that will help the physician recognize drug abuse and manage it effectively.

Reprinted from the March 1986 issue of American Family Practice

Hallucinogens

All of the hallucinogens, or psychedelics, affect the pons, which is the bridge between the higher and lower cortical centers. More specifically, hallucinogens act on the pontine raphe nuclei, decreasing neuronal firing and serotonin turnover.

LSD

The classic hallucinogen in the United States is LSD (lysergic acid diethylamide), a semisynthetic derivative of ergonovine. First developed in 1943, LSD could be used legally in the United States until 1968. It is a very potent drug: the ingestion of only 0.5 μg can produce a "high" that lasts up to 12 hours in a man weighing 70 kg (155 lb). Two factors have contributed to LSD's popularity as a hallucinogen: it is nonaddictive, and it can be manufactured by a person who has had only one year of college chemistry.

When LSD is taken in doses of 20 to 400 μg, various hallucinations involving synesthesia, or cross-sensory perception, can occur. With synthesia, the user can hear or



taste colors and smell sounds. Hallucinations of this type are not encountered in any form of functional psychosis. Other signs and symptoms of LSD intoxication include mydriasis, blurred vision, distorted sensations (perceptions of self-image, time, space, etc.), mental dissociation, tremors, hyperreflexia and mood swings.

LSD has numerous street names. When sold in gelatinous form, it is called "windowpane." LSD soaked into paper becomes "blotter"; the drug is sometimes soaked into Mickey Mouse decals, which are called "Mickies." LSD in tablet form is known as "microdot," while the capsule form is "Mr. Natural" or "blue devil."

NUTMEG

Drug users who do not know how to manufacture LSD or who do not have access to the drug often use nutmeg as a hallucinogen. The most frequent abusers of nutmeg are children and adolescents who cannot obtain street LSD. Because nutmeg contains lysergide as well as eugenol, geraniol, safrol and borneol, it is perhaps the most potent hallucinogen available. Approximately 5 mg of nutmeg contains enough LSD equivalent to keep the user "high" for eight to 12 hours.

A deterrent to the use of nutmeg is that one of its components, geraniol, is about three times as potent as ipecac in inducing emesis. In an attempt to avoid emesis, users often mix nutmeg with cola prior to ingestion. As a result, nutmeg is sometimes referred to as "brown slime." The user who can keep from vomiting nutmeg can experience a variety of hallucinations, including synesthesia.

LSD has numerous street names. When sold in gelatinous form, it is called "windowpane"; soaked into Mickey Mouse decals, it becomes "Mickies."

MESCALINE

Some drug users experiment with more exotic hallucinogens, such as mescaline (3,4,5-trimethoxyphenylethylamine). This drug is derived from the peyote cactus, *Lophophora williamsii,* a small plant (approximately three inches in diameter) with soft spikes and small pink or red flowers. The peyote cactus can be purchased at discount stores or plant shops. The dried flower heads of this cactus, known as "mescal buttons," give mescaline the street name "button." The drug is also called peyote, "mesc" and "moon."

Mescaline achieves its effects by stimulating adenylate cyclase activity at central dopaminergic receptors in anterior limbic structures. This drug, which is rapidly absorbed, causes hallucinations and temporary psychosis. The user often hallucinates that he is being followed by marching geometric shapes; this specific hallucination can be useful in making the diagnosis.

PSILOCYBIN

Psilocybin is isolated from the mushroom *Psilocybe mexicana.* Although this mushroom grows primarily in Mexico, it can be found along many streams throughout the United States. Ingestion of one or two mushrooms in a dried form can produce hallucinogenic effects that last approximately six hours. A unique characteristic of psilocybin is that it causes chromatopsia. For example, the psilocybin user may perceive the picture on a black-and-white television set to be in color.

MORNING GLORY SEEDS

Morning glory seeds, which can be purchased from almost any seed catalog company, contain lysergol, d-lysergic acid amide and d-isolysergic acid amide. An average-sized man who ingests five morning glory seeds or an average-sized woman who ingests three seeds will "trip" for approximately 16 hours.

To discourage ingestion, morning glory seeds are sometimes sprayed with paraquat, a toxic herbicide. Users often dip the seeds in ether, which effectively dissolves the herbicide. Nonetheless, the physician should watch for signs of neurotoxicity in a known or suspected morning glory seed user. The abuser may have been unaware that the seeds were coated with paraquat or some other herbicide, or may not have known that ether would remove the coating.

Street names for morning glory seeds include "heavenly gates" or "pearly gates," which refer to the names used by the seed companies. The seeds are also called "flying saucers," because they are somewhat round, or "licorice drops," because they are small and black.

DMT

DMT (dimethyltryptamine) is a potent short-acting hallucinogenic substance that occurs naturally in several varieties of South American and West Indian plants. Onset of the hallucinogenic effect is instantaneous after inhalation of the substance, or after intramuscular or intravenous injection of the synthetic form. The street name for DMT is "the businessman's lunch," because the effects of the drug last for exactly one-half hour and because high-powered businessmen are known to use DMT. The drug is also called "snuff."

Recently, the drug called "ecstasy," 3, 4 methylenedioxymethamphetamine (MDMA), which is related to both the hallucinogens and the amphetamines, has become popular. Treatment for overdose is similar to that for LSD or other hallucinogens.

Like DMT, this drug is often referred to as "the businessman's lunch" because it is fast-acting and short-lived. "Ecstasy" increases sexual potency in men and increases libido in both men and women. The drug also causes a delusion of physical merging that heightens the psychologic aspect of sexual play.

TREATMENT

Treatment for hallucinogen intoxication consists of providing support until the drug effects have worn off. The patient should be placed in a semi-dark room and made comfortable. A person with whom the patient is familiar or one who can provide warmth, empathy and reassurance should talk to the patient. "Talking the patient down" from the effects of a hallucinogen will take two to 12 hours.

If the patient is overwhelmingly anxious, the physician can administer a mild tranquilizer or diphenhydramine (Benadryl®). Antipsychotic agents should be avoided since the drug-induced psychosis will resolve spontaneously. Furthermore, there is always the possibility that the hallucinogen may have been mixed with phencyclidine or some other illicit drug that may worsen the patient's condition if antipsychotics are used.

'Uppers'

AMPHETAMINES

Amphetamines are the drugs most frequently abused by health care professionals. They are central nervous system stimulants, commonly referred to as "uppers." Amphetamines in the d-form have greater effects on the central nervous system than do amphetamines in the L-form, which act peripherally. Because amphetamines work on both alpha and beta receptors, they have many systemic effects, including potentially hazardous cardiovascular reactions.

Other effects of amphetamine abuse include suppressed appetite, accelerated thinking, increased sex drive, decreased desire to sleep and a feeling of excitement ("buzz"). The amphetamine abuser often loses respect for authority and becomes combative. Furthermore, amphetamines, like alcohol, decrease the user's perception of errors.

Amphetamines cause the release of catecholamines into the synaptic cleft and decrease the rate of catecholaminergic neuronal firing. Centrally, this occurs in the basal ganglia and olfactory tubercle. Chronic amphetamine users may "crash," or become depressed, because they have depleted their stores of catecholamines in the brain.

Other signs and symptoms of amphetamine abuse include tachycardia, cardiac arrhythmias, circulatory collapse, restlessness, anxiety, dilated pupils, blurred



vision, high fever, abdominal cramps, headache, tremors, hyperactive reflexes and hypertension (or hypotension), coma and respiratory failure.

On the street, amphetamines are known as "black beauties," "uppers" and "Christmas trees." When methylated, amphetamine becomes methamphetamine, which acts centrally almost exclusively. Methamphetamine is sold under the names "speed," "crystal," "meth" and "white crosses."

PHENYLPROPANOLAMINE HYDROCHLORIDE

Phenylpropanolamine hydrochloride, which is contained in many sinus tablets and diet pills, is similar to amphetamines and is often substituted for them. It is the active agent in the green plant *Catha edulis,* called khat, whose leaves are chewed to achieve an amphetamine-like effect.

CAFFEINE

Caffeine is a widely abused drug that is often overlooked as a cause of acute reactions. Like amphetamine, caffeine stimulates the central nervous system. It inhibits cyclic nucleotide phosphodiesterases, thereby elevating levels of cyclic adenosine monophosphate (cAMP) and cyclic guanosine monophosphate (cGMP).

Caffeine can be lethal; children have died after ingesting less than 1 g of the drug. Ten No-Doz® pills (100 mg of caffeine per tablet), eight cups of coffee (125 mg per cup), 12 cups of tea (80 mg per cup), or three to five bottles of carbonated cola drinks (125 mg per cup) can give the user a caffeine "buzz." The symptoms of caffeine withdrawal are the same as those of caffeine overdose: restlessness, tremors, hyperreflexia, anxiety, mild headache, nausea, abdominal cramps, palpitations, arrhythmias and tachycardia.

TREATMENT

The patient who presents while high on a central nervous system stimulant should be talked down. If the patient has overdosed, panic should be avoided. The patient should be observed, and the vital signs and electrical activity of the heart should be monitored. After the patient has "crashed," an antidepressant with low cardiotoxic effects, such as desipramine (Norpramin®, Pertofrane®) or nortriptyline (Aventyl®, Pamelor®), should be administered. To accelerate renal excretion, the urine should be acidified with ammonium chloride, 1 to 2 g orally every six hours; diuresis should then be induced by intravenous administration of furosemide (Lasix®), 20 to 40 mg. In conscious patients, emesis can be induced with ipecac syrup. Comatose patients should be intubated, and gastric lavage should be performed. The administration of 50 g of activated charcoal in 500 mL of water will help decrease absorption of the drug. Magnesium sulfate is useful as a cathartic. To combat aggressiveness, agitation and hallucinations, 5 mg of haloperidol (Haldol®) can be given orally as needed.

If the user did not ingest USP-quality amphetamines (such as those stolen or obtained from a pharmacy or a physician's office) but instead obtained amphetamines on the street, other problems can arise. For example, the user may have ingested phencyclidine hydrochloride (PCP) instead of, or with, the amphetamines.

PCP

PCP and its metabolite phenylcyclohexyl pyrrolidine (PHP) are termed dissociative drugs. PCP was first studied as a potent nonnarcotic anesthetic agent for use in humans. However, because the drug seemed to induce adverse behavioral reactions resembling those seen in schizophrenia, it was withdrawn from clinical trials. During the 1960s, PCP was introduced on the market as a tranquilizer for use in veterinary medicine. PCP abuse then became so widespread that all legal production of the drug ceased in 1978.

PCP is a popular drug of abuse because it is both easy and

inexpensive to manufacture. The only materials required to manufacture this drug are a porcelain bowl, some nickels, piperazine and L-tryptophan. One "hit" of PCP costs about five cents to make.

Because PCP has a wide range of effects on behavior and can be taken in a variety of forms, it can be sold on the streets disguised as other drugs. Also known as "angel dust," "hog" and "porker," PCP can be sniffed, snorted, taken orally in tablets or capsules, rubbed on the tongue or injected. PCP can also be mixed with parsley or oregano, or with such drugs as marijuana. PCP can even be taken in an enema.

PCP affects almost every neurotransmitter receptor system in the brain. The dopaminergic, gamma-aminobutyric acid (GABA)-ergic, noradrenergic and serotoninergic systems are affected by the drug, as are the endorphins and opiate receptors.

Because PCP affects so many neurotransmitters, the clinical picture of intoxication can vary. Furthermore, the symptoms depend on the amount of drug the user has taken. If the user has taken approximately 5 mg, such symptoms as anxiety, ataxia, excitement, flushing, conceptual disorganization and hallucinations may appear. If the user has taken 5 to 10 mg of PCP, signs and symptoms include fever, amnesia, hyporeflexia, myoclonus, stupor, hypersalivation and coma. More than 10 mg of PCP can lead to delusions, hypertension, hyporeflexia, opisthotonos, convulsions, coma and death.

TREATMENT

Treatment of PCP intoxication varies. At present, no specific antidote exists. Treatment relies on reassurance, protection from harm, acidification of the urine and diuresis. In mild cases, acidification can be accomplished by oral administration of ascorbic acid, 1 g every six hours, and ingestion of cranberry juice, which contains hippuric acid. In cases of moderate to severe intoxication, ammonium chloride may be needed to acidify the urine. Sodium sulfate can be administered through a nasogastric tube to promote fecal elimination. Convulsions can be treated by intravenous administration of 2 to 5 mg of diazepam (Valium®). For hypertension and arrhythmias, 1 mg of propranolol (Inderal®) can be administered intravenously. Because of the atropine-like effects of PCP, patients should be monitored for cardiac arrhythmias. A respirator may also become necessary to support breathing.

Other treatment measures depend on the clinical picture. If the patient is psychotic but not hallucinating, 2 mg of physostigmine (Antilirium®) should be administered intramuscularly every 20 minutes; most patients improve by the third dose. If the patient is hallucinating, 5 mg of haloperidol should be given intramuscularly every 20 minutes; improvement usually occurs after the second dose. Other neuroleptics can also be used. It has recently been shown that meperidine (Demerol®), 50 mg intramuscularly, produces a greater overall improvement in the clinical picture after 30 minutes than does chlorpromazine (Thorazine®).

PCP is a popular drug of abuse because it is both easy and inexpensive to manufacture.

'Downers'

BARBITURATES

First synthesized in 1864 and released to the American medical profession in 1903, barbiturates have had wide use as tranquilizers, anticonvulsants and preoperative sedatives. They have also become popular drugs of abuse, known on the street as "yellow jackets," "reds" and "barbs."

Barbiturates decrease the activity of postsynaptic cGMP and cAMP in the central nervous system. These drugs are metabolized in the liver, where induction of hepatic enzymes can lead to tolerance and interaction with other drugs that are also metabolized in the liver. As tolerance develops, the abuser must continually escalate the barbiturate dose needed to produce the desired effect. Although barbiturates are soporific, they can cause paradoxic excitement in children and geriatic patients.

While moderate barbiturate intoxication resembles inebriation with alcohol, severe intoxication can result in coma. Other signs and symptoms include disorientation, sleeplessness, flaccid muscles, decreased reflexes, hypotension, shock, pulmonary edema and pneumonia. The lethal dose of barbiturates varies but is generally about 10 times greater than the hypnotic dose if it is taken within a short period, such as three hours. Overdose of short-acting barbiturates has the highest mortality rate.

Treatment of barbiturate overdose is symptomatic and supportive. An adequate airway should always be maintained, and artificial respiration may become necessary. Emesis should be induced in the conscious patient, with adequate measures taken to prevent aspiration of vomitus. Mannitol diuresis may accelerate renal elimination of barbiturates. Hypotension and shock can be treated initially with intravenous fluids. However, norepinephrine bitartrate (Levophed®) may be required. Finally, hemodialysis is useful when blood drug levels are high in long-acting barbiturate poisoning.

Abrupt withdrawal from heavy use of a barbiturate can lead to death. Signs of withdrawal include anxiety, arrhythmias, convulsions, delirium, fever, hyperreflexia, irritability, hypotension, tremor and weakness. These manifestations may occur with 72



hours after cessation of barbiturate intake.

Since barbiturate withdrawal has a significant mortality rate, it should always be undertaken in a hospital. During withdrawal, 30 mg of phenobarbital should be given orally for each 100 mg of the short-acting barbiturate to which the user is addicted. The dosage should be reduced by 30 mg each day thereafter. If withdrawal symptoms appear, the patient should be given 200 mg of sodium pentobarbital (Nembutal®) orally, and the withdrawal schedule should be modified.

When the degree of barbiturate addiction is unknown, a pentobarbital test dose of 200 mg may be given orally. The patient's sensorium should be checked one hour after the pentobarbital has been ingested. The physician can determine the probable degree of addiction from the following observations: patient is drowsy but arousable — assumed habit of less than 400 mg barbiturate per day; patient has slurred speech and nystagmus — 400 to 600 mg per day; patient has nystagmus alone — 600 to 1,000 mg per day; no symptoms — over 1,000 mg per day.

Methaqualone, called "lude" on the streets, is one of the most widely abused drugs in the U.S. It is stored in body fat, so treatment of overdose is difficult.

BENZODIAZEPINES

Benzodiazepines, referred to on the street as "Roches," "tranks" and "pumpkin seeds," are antianxiety agents that possess less potential for abuse than barbiturates or other sedative-hypnotics. Dependence requires the chronic administration of at least five times the therapeutic dose for approximately three to four months. Deaths from overdose are rare, since these drugs possess a high therapeutic index. Deaths do occur, however, when benzodiazepines are taken in combination with alcohol, propoxyphene (Darvon®) or other central nervous system depressants.

The anxiolytic action of these agents is due to benzodiazepine binding at co-receptor sites that enhance GABA binding and effect. GABA is the principal inhibitory neurotransmitter of the central nervous system, acting as a switch that controls the other neuroregulatory systems.

Signs and symptoms of acute benzodiazepine overdose include nystagmus, ataxia, confusion, slurred speech, hypotension and depressed respiration. Hypotension can be treated with norepinephrine bitartrate (four 4-mL ampules per 250 mL of saline at 80 to 100 mL per hour). If respiratory arrest occurs, the patient should be hyperventilated with pure oxygen; ventilatory support may become

necessary. Following intubation, gastric lavage and the administration of activated charcoal may remove some of the drug.

Abrupt discontinuance of a benzodiazepine may cause severe withdrawal symptoms, such as convulsions or psychosis. Therefore, withdrawal should always be carried out gradually. The patient should be reintoxicated with diazepam in a dosage equivalent to prior use; the dosage should then be gradually reduced over a period of five to 10 days. Administration of propranolol, 20 to 40 mg three times daily, can reduce the severity and/or duration of withdrawal.

METHAQUALONE

Methaqualone (Quaalude®, Sopor®), called "lude" on the street, is one of the most widely abused drugs in the United States. It is quickly absorbed from the gastrointestinal tract and is almost completely metabolized in the liver. Methaqualone has a half-life of about three hours.

Because methaqualone is stored in body fat, treatment of overdose is difficult. Treatment may be further complicated if the drug has been used in combination with alcohol or some other intoxicating substance. Since methaqualone exerts a depressant effect on the myocardium, cardiac monitoring is necessary for the first three days after overdose. Convulsions should be treated with diazepam, 5 to 10 mg, administered in a slow intravenous push. Barbiturates should never be used to treat convulsions.

Detoxification is accomplished by administering 100 mg of phenobarbital every six hours for the first day of treatment and then decreasing the dosage by 10 percent per day. Coma has occurred with acute overdoses averaging 2.4 g. If the patient is comatose, hemodialysis therapy should be initiated.

ETHCHLORVYNOL

Known on the street as "Mr. Green Jeans," "pickles" and "jelly beans," ethchlorvynol (Placidyl®) is a frequently abused drug with only a small margin of safety. Deaths have occurred with as little as three to six times the average daily dosage of this drug. Overdose may be further aggravated if ethchlorvynol has been taken in combination with alcohol or tricyclic antidepressants.

Ethchlorvynol has a rapid onset and a short duration of effect (about three hours). Peak blood levels are reached 60 to 90 minutes after the drug is ingested.

The clinical presentation of ethchlorvynol overdose can include bradycardia or cardiac arrest, depression, hypotension, hypothermia, pulmonary edema and respiratory arrest. Treatment, which is supportive and symptomatic, includes furosemide for pulmonary edema, airway maintenance and hyperthermic blankets to combat hypothermia. Gastric lavage, ipecac and activated charcoal are also useful.

MEPROBAMATE

Meprobamate (Equanil®, Miltown®) is the most frequently abused member of the carbamate derivatives, a group of drugs possessing sedative-hypnotic properties. Common street names include "bams" and "Uncle Milties." Since meprobamate is rapidly absorbed from the gastrointestinal tract, peak plasma levels are reached one to two hours after ingestion.

The presence of enterohepatic circulation, incomplete gastric emptying and delayed absorption complicate the management of meprobamate overdose. The lethal meprobamate dose varies from 12 to 40 g. The usual dosage of meprobamate is 800 mg per day, in two to four doses. Slightly higher doses taken chronically can lead to dependence and withdrawal symptoms. To avoid convulsions during detoxification, meprobamate dosage should be tapered slowly by 10 percent per day or every other day. Alkalization of the urine with sodium bicarbonate will hasten excretion of the drug.

Marijuana is second only to alcohol as a drug of abuse among college students. More than 25 million Americans over the age of 12 have tried marijuana at least once.

Marijuana

Marijuana is second only to alcohol as a drug of abuse among college students. More than 25 million Americans over the age of 12 have tried marijuana at least once. The more than 50 street names for this drug, ranging from "Acapulco gold" to "weed," testify to its widespread use in American society.

Marijuana comes from the leafy green plant *Cannabis sativa,* whose active ingredient is delta-9-tetrahydrocannabinol (THC). Marijuana is usually smoked, although it can be eaten and is often baked in brownies. Addicts can also purchase THC and take it orally.

Marijuana acts on the hypothalamus and on the striate bodies. Small doses of the drug cause mild euphoria, psychosedation and motor retardation. Larger doses may induce feelings of depersonalization, hallucinations and paranoia.

Support and empathic understanding are the keys to the treatment of marijuana overdose. Medical care is seldom required. If agitated, the patient should be

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placed in a dimly lit room with minimal external stimuli. Hallucinations and delusions can be treated by administering 5 mg of haloperidol intramuscularly. If a panic reaction occurs, 5 to 10 mg of diazepam should be given. Because marijuana is often sprayed with paraquat or laced with PCP, physicians need to watch for signs of neurotoxicity or PCP intoxication.

Cocaine

Cocaine has become an extremely popular drug among the wealthier segments of American society. Derived from the dried leaves of the coca plant, *Erythroxylon coca,* the drug costs about $100 per gram. Considerable attention has been given to cocaine and its effects on the lives it touches, especially when prominent sports figures, film stars and wealthy businessmen are involved.

Known as "coke," "white girl" and "toot," cocaine can be injected, snorted or taken orally. In some cases, it is dissolved in an alkaline solution to make cocaine sulfate, called "freebase," which is then smoked.

Acute cocaine intoxication is similar to amphetamine intoxication. Initially, the drug stimulates the heart rate and blood pressure. Vasoconstriction, hyperpyrexia of up to 40°C (104°F) and mydriasis are also characteristic signs of cocaine abuse. Cardiotoxic effects that can occur with acute cocaine intoxication include arrhythmias, circulatory failure, convulsions, respiratory failure and coma. Toxic psychotic states with associated hallucinations and paranoia can result from large doses of the drug. Any patient suspected of cocaine abuse should be examined for nasal signs, since chronic abuse can lead to nasal septum perforation due to irritation from snorting.

Treatment of cocaine overdose includes electrocardiographic monitoring, as well as monitoring of the vital signs. If mid-brain respiratory center depression occurs, artificial respiration may be required. Cardiotoxicity can be treated with intravenous administration of propranolol, 1 mg per minute to a maximum of 8 mg. Psychosis should be treated with 5-mg doses of haloperidol at one-hour intervals; three doses are usually sufficient.

No pharmacologic intervention is needed during cocaine withdrawal. Instead, the patient should receive sympathetic support and should be placed in a dimly lit room with minimal external stimuli until the effects of the drug have worn off.

Opiates

Opium is derived from the sap of the wild poppy, *Papaver somniferum,* and is refined to form morphine and heroin. Synthetic opiates, which are also widely abused, include meperidine, propoxyphene and pentazocine. Street names for heroin include "horse," "skag" and "smack."

Opiates block mu and delta endorphin receptors in the central nervous system. These receptors were called opiate receptors until endorphins were discovered in 1976. Endorphins have since been implicated in a wide range of psychiatric disorders, including depression, mania and schizophrenia. They are also responsible for many of the signs and symptoms seen in opiate intoxication and withdrawal.

Many of the adverse reactions to opiates, such as pulmonary edema, respiratory depression and coma, can be treated by administering 0.4 to 0.8 mg of the opiate antagonist naloxone (Narcan®) in an intravenous bolus every 20 minutes. If this regimen fails, the dosage of naloxone can be increased by 2 to 4 mg until a maximum of 24 mg is reached. Detoxification can be accomplished by administering clonidine (Catapres®), 17 μg per kg in three or four divided doses daily. This dosage is then tapered over one to two weeks.

Final Comment

As long as people need to feel unnatural "highs" and "lows" in order to cope with their daily activities, substance abuse will continue to be a major problem. In addition to the basic treatments discussed in this article, counseling and psychotherapy are keys to maintaining recovery after detoxification. To assure their continued health and well-being, patients must accept that they have been chemically dependent and receive help in finding new techniques for coping with the stresses in their lives.

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A. James Giannini, MD, graduated from the University of Pittsburgh School of Medicine and served a psychiatric residency and fellowship at Yale University School of Medicine, New Haven, Conn. He is professor of psychiatry at Northeastern Ohio Universities College of Medicine, Rootstown, and is clinical professor of psychiatry at Ohio State University College of Medicine, Columbus. Dr. Giannini also serves as cochairman of the National Advisory Commission on the Prevention of Rape for the Department of Health and Human Services, Washington, D.C. He has written five books and nearly 100 articles on clinical psychiatry.

William A. Price, MD, graduated from Northeastern Ohio Universities College of Medicine, Rootstown. Dr. Price is currently serving a psychiatric residency at the University of Pittsburgh Western Psychiatric Institute and Clinic. He has written several chapters in books and more than 50 articles on clinical psychiatry.

Matthew C. Giannini, JD, is a practicing attorney and a senior partner in the firm of D'Apolito, Infante and Giannini, Youngstown, Ohio. A graduate of Youngstown State University and Dayton University School of Law, Ohio, Mr. Giannini is associate professor of forensic psychiatry at Northeastern Ohio Universities College of Medicine and Youngstown State University. He has written many articles, chapters and a book on drug abuse.

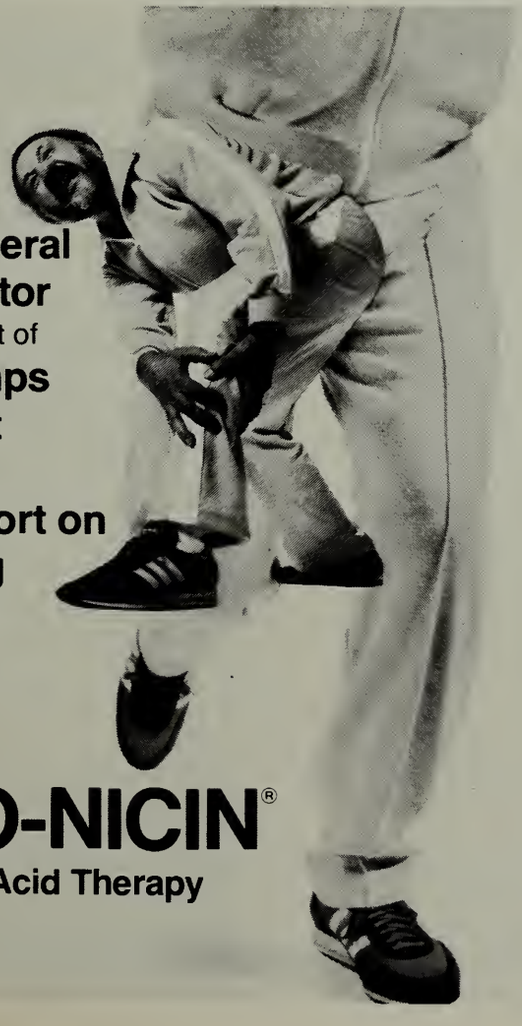


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The Physician's Role

Treating Alcohol and Drug Abuse

By Susan Porter

It's been called the most neglected health care problem in the United States. And even for those individuals who find it hard to sympathize with the patient who gets hooked on drugs or alcohol or both, it's difficult to overlook the effects of substance abuse on the health care system.

Consider for example that:

• Alcohol is a factor in nearly half of all automobile accidents where the driver is killed and in one-third of all accidents where adult pedestrians die.

• Employees who use drugs or alcohol on the job are three times as likely to be injured as those who do not. Worker alcoholism costs American business more than $19 billion in lost production time each year.

• Pregnant women who abuse alcohol are twice as likely to suffer miscarriages. Fifty percent of all pregnancies where alcohol abuse occurs have some type of abnormality.

• Children of alcoholics are frequently victims of child abuse, incest, neglect or violence. They also are at higher risk of developing alcoholism themselves or marrying an alcoholic.

• Alcohol use by children and adolescents may indicate the development of more serious and damaging risk-taking behavior, such as drug use and even suicide.

• The elderly are especially susceptible to drug abuse, some of it the result of overprescribing by physicians unaware of the total amount of medications their patients are receiving. Alcoholism is also common among those retired individuals who become bored, lonely or depressed.

Thus — like it or not — substance abuse touches every segment of society and has a direct impact on nearly every specialty in medicine. Whether you're an emergency room physician treating a broken arm, an obstetrician delivering an underweight infant, a pediatrician examining an abused child, or a geriatrician prescribing for an elderly patient, the chances that you are treating a victim of alcoholism or drug abuse are surprisingly great, says Gregory B. Collins, MD, director of drug and alcohol abuse rehabilitation program at the Cleveland Clinic.

Dr. Collins, who addressed the Psychiatry Section at the Ohio State Medical Association 1986 Annual Meeting last May, says that alcohol and drug abuse are "extremely common disorders — and we are only seeing the tip of the iceburg."

And while some physicians may overlook these factors as they set broken bones, treat cuts and bruises, or prescribe sedatives or anti-depressants, "the problem is right there under our noses," Dr. Collins continues. "It is estimated that 20% of the U.S. population



will have a problem with alcohol at some time in life — and 7% to 10% have one right now,'' he says. "You don't have to look very far to see it.''

Yet when it comes to diagnosing alcoholism, physicians "often have their blinders on,'' says Dr. Collins. "Consciously or unconsciously, we like to deny the problem exists.''

Among the reasons many physicians tend to look the other way is what Dr. Collins terms "the defeatest's viewpoint.'' Those not up-to-date on the treatment of alcohol and drug abuse may feel it is a hopeless problem with no real medical solution.

Some physicians tend to avoid the issue of alcoholism for fear the patient may become too demanding or dependent, while others simply feel uncomfortable with the alcoholic patient.

"A lot of people ask us, 'How can you stand to work in that field,' '' Dr. Collins relates. Yet physicians have a responsibility to treat the whole patient, he adds, to recognize the possibility of addiction, along with the broken arm, the delivery of a premature infant or the depression. Why? Because a doctor is in a key position to make the situation better or worse, says Dr. Collins. If the situation is ignored or mismanaged, it will only get worse, he explains. However, even those physicians not trained in working with alcohol or drug abuse can make an invaluable contribution towards a patient's recovery — first by recognizing that the problem exists, and then by steering the patient towards the proper source of care.

Is my patient an alcoholic?

To some, a fine line exists between the patient who frequently has "one too many'' on business and social occasions and the alcoholic. Yet current medical thinking considers alcoholism a biologically influenced physical illness, rather than a moral weakness, which strikes only a certain percentage of the population.

"Alcoholism is now generally viewed to be a disease of addiction,'' says Dr. Collins, "involving a dependency or a harmful involvement with alcohol and/or other addictive drugs.''

While the pathophysiology of the disease is still uncertain, according to Dr. Collins, alcoholism is a complex disorder, involving both body and mind. "It is the result of complex factors: environmental, psychological, physical, social and cultural,'' he says.

If the disease is difficult to categorize, it is even harder to diagnose. "Alcoholism is a great masquerader,'' says Dr. Collins, "disguising itself as a number of

There are no pat and simple diagnostic tools for determining whether or not substance abuse is involved. So look at some related problems.

medical or psychological complaints.'' Hypertension, seizures, gastric ulcers, anemia, hepatitis, TB, VD, and heart disease, along with anxiety and depression — all can be signs and symptoms of alcoholism.

Yet there are no pat and simple diagnostic tools for determining whether or not substance abuse is involved. Therefore, Dr. Collins suggests looking at some related problems.

"Look for signs in the patient's marriage, job, emotional status, legal status, financial status, spiritual health and physical health,'' says Dr. Collins. "Most physicians are uncomfortable asking their patients about their marriages on their jobs — but these are two of the earliest indicators and will precede other problems caused by drinking by many years.''

A simple inquiry as to how things are going at home or at work could open the conversation. If infidelity, frequent fighting, lies, separations and divorce are mentioned, it could be a sign there is also a problem with alcohol at home. Absenteeism, lateness, leaving work early, long lunches, declining performance, wage cuts and loss of a job are good indications that alcoholism is affecting the patient's work.

Financial problems are among other signs: too much drinking can lead to unpaid bills, lower wages, tax problems, irresponsible spending and poor financial investments, while legal complications can be among other indicators: arrests or convictions, drunk driving, public intoxication, assaults, domestic violence, etc.

Finally, if the patient has had an extraordinary number of emergency room visits or treatment due to auto accidents, injuries, falls, etc., alcoholism could be a factor.

If the physician does suspect involvement with alcohol, Dr. Collins' next suggestion is to "take a good drinking history.'' Ask the patient about his/her lifelong drinking habits, starting with the first drink and ending with the present day. Did he/she drink in high school? College? In the military? Does he/she drink frequently at home or on the job?

Two key questions to ask when a patient comes in for care are: 1. Did your problem have anything to do with drinking? 2. Had you been drinking when the problem occurred?

If so, the chances are good that alcoholism could be a critical factor.

Confronting the alcoholic patient

Surprisingly, says Dr. Collins, when all of the facts are laid out on the table, a patient seldom denies there is a problem with alcohol, although it's best not to outright accuse the patient of being "an alcoholic.'' Rather, "allow the patient the dignity of a self-diagnosis,'' he says. This can be facilitated with phrases like, "If I asked you, would you say you might have a problem with drinking?''

Where most of the difficulties arise, however, are in getting the patient to admit he or she needs help with the problem. "Usually the patient offers to 'cut down' on drinking or to 'take care of the problem' himself or herself,'' says Dr. Collins. This, however, rarely is successful.

Thus an appropriate response, says Dr. Collins, is to emphasize that immediate treatment is needed. "Emphasize the worsening progression of this disease, the physical deterioration, the more severe social complications, the more frequent intoxication. Make it clear that if the patient doesn't act now, more bad things are going to happen. Be optimistic, but be firm and persistent — because if you don't persist, the patient will eventually die from this.''

Selecting proper treatment

The physician may also help convince the patient to seek professional help by explaining the treatment. Addicted patients who try to withdraw from alcohol alone may experience withdrawal symptoms: shakes, sweats, insomnia, nausea and vomiting, followed by confusion and a disordered sense of perception. However, under the proper medication and with constant supervision, the alcoholic can pretty well "sleep off'' those first four or five difficult days.

If possible, inpatient care or hospitalization is the best alternative for treating the alcoholic patient, at least during the initial stages of detoxification, says Dr. Collins. While a variety of programs exist throughout the state, the most effective have several key components: detoxification, rehabilitation and long-term follow-up care.

"And don't underestimate the importance of Alcoholics Anonymous,'' says Dr. Collins. "AA is to the alcoholic what insulin is to the diabetic.''

In fact, Dr. Collins suggests the patient should call on AA when still in the hospital and should attend at least three to four AA meetings per week following his/her dismissal. For the addict, "every life turbulence leads to chemicals and presents the danger of a relapse,'' he says. Yet

Continued on page 521

The Children of Alcoholic Parents

By Charles Hart Enzer, MD

Seven million American children have alcoholic parents. Child psychiatrists know these children have a significant risk for emotional problems. Alcoholism runs in families, and children of alcoholics are four times more likely than other children to become alcoholics.

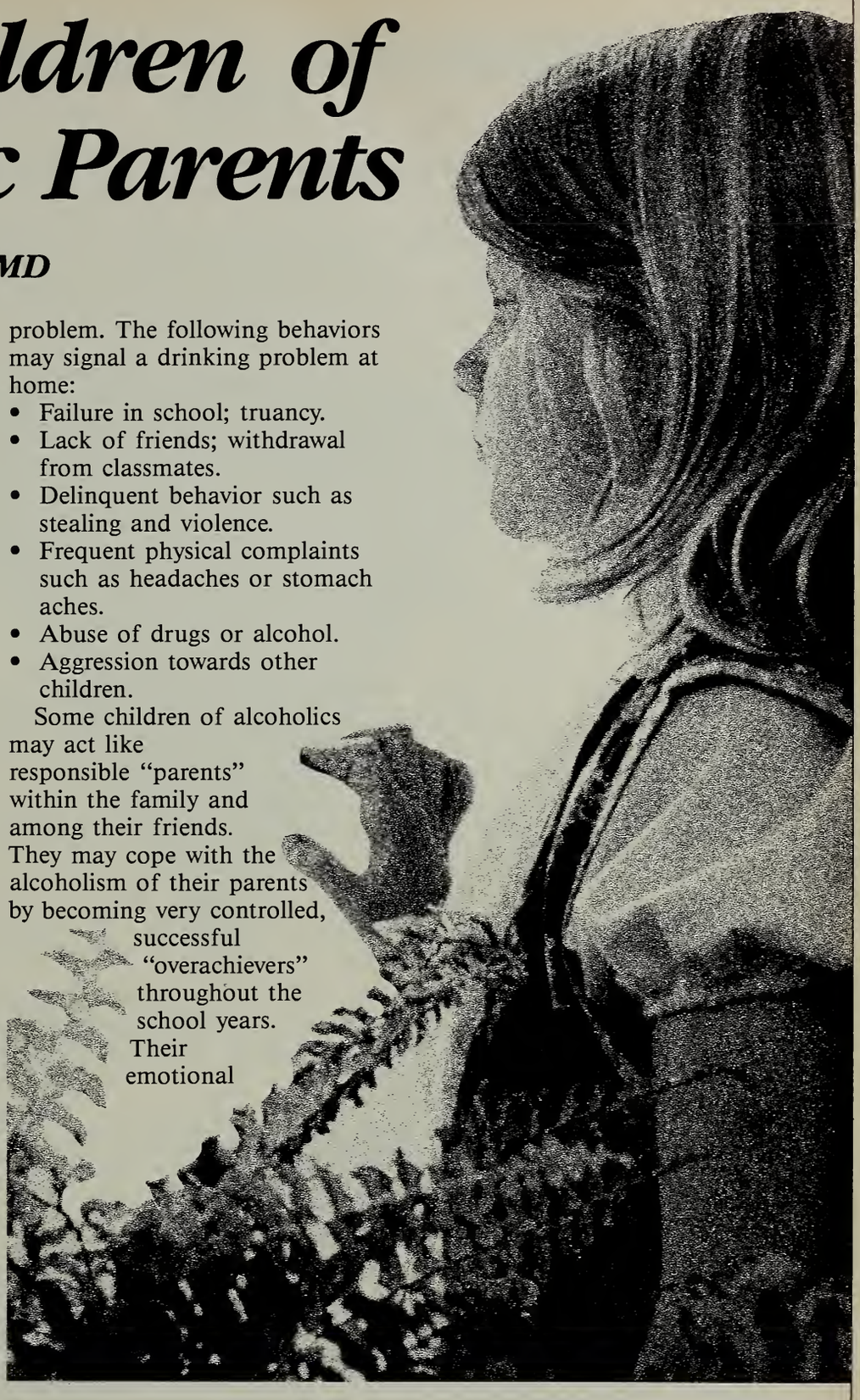
A child of an alcoholic parent may develop:

- **Guilt.** The child may see himself or herself as a cause of the parent's drinking.
- **Anxiety.** The child may worry constantly about the situation at home. He or she may fear the alcoholic parent will become sick or injured, and may also fear fights and violence between the parents.
- **Embarrassment.** Alcoholic parents may give the message that there is a terrible secret at home. The ashamed child may not invite friends home and may fear to ask anyone for help.
- **Inability to have a close relationship.** Because the child has been disappointed by the drinking parent many times, he or she may not trust others.
- **Confusion.** The alcoholic parent may change suddenly from being loving to angry, regardless of the child's behavior. A regular daily schedule, which is very important for a child may not exist because of bedtimes and mealtimes constantly changing.
- **Anger.** The child may feel anger at the alcoholic parent's drinking, and may be angry at the non-alcoholic parent for lack of support and protection.

Although a child tries to keep the alcoholism a secret — teachers, relatives, and other adults or friends may sense that there is a problem. The following behaviors may signal a drinking problem at home:

- Failure in school; truancy.
- Lack of friends; withdrawal from classmates.
- Delinquent behavior such as stealing and violence.
- Frequent physical complaints such as headaches or stomach aches.
- Abuse of drugs or alcohol.
- Aggression towards other children.

Some children of alcoholics may act like responsible "parents" within the family and among their friends. They may cope with the alcoholism of their parents by becoming very controlled, successful "overachievers" throughout the school years. Their emotional problems may show only when they become adults.



Appropriate professional help — the earlier the better — is important in preventing more serious problems for the child, including the threat of alcoholism. Children of alcoholics need to understand that they are not responsible for their parents' drinking problems. Treatment programs may include group medical psychotherapy with other youngsters, reducing the isolation of being a child of an alcoholic. Treatment may also involve family — particularly when the alcoholic parent has stopped drinking — so family members can develop healthier ways of relating to one another. — *Charles Hart Enzer, MD, practices psychtalcyia child, adolescent, adult and family psychiatry in Cincinnati.*

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If the patient can go for two years "clean, dry and chemical free," chances of relapse are slim.

complete abstinence is the only way the alcoholic will survive. "Cutting back just doesn't work," he says.

The same holds true for those addicted to any of the numerous opiates — morphine, heroin, Darvon, Demerol, etc. Yet complications and withdrawal can even be more severe without complete supervision in a hospital setting. Again, medication is used to help buffer possible withdrawal symptoms: tremors, chills, fever, agitation, resistance, seizures, vomiting, diarrhea, panic, depression, anxiety and irritability.

"You don't die from opiate withdrawal," says Dr. Collins, "but a number of complications can set in."

Ironically, street addicts require less detoxification medication than health care workers who get hooked on opiates, because the latter generally have access to stronger and purer forms of the drug, says Dr. Collins. Also, the detoxification must be carefully timed so that withdrawal doesn't occur too rapidly. "Otherwise you may end up with an angry patient — who will go right back to using the drugs," says Dr. Collins.

In the end, it is the patient who will determine the success or failure of a particular treatment program. If that patient can go for two years "clean, dry and chemical free," chances of relapse are slim, says Dr. Collins.

However, the constant attention and follow-up care of a physician not afraid to look the problem squarely in the eye — alongside the patient — is a critical part of the recovery process and reaching that two-year goal.

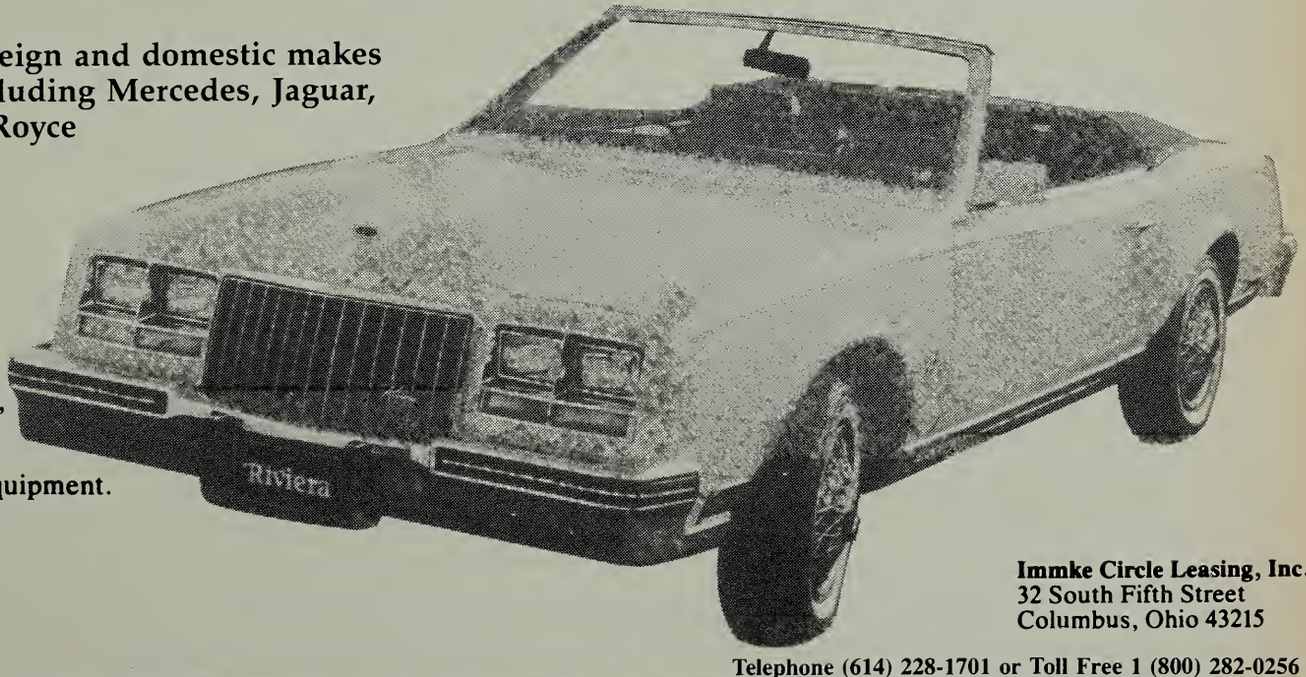
While the non-addict may have a hard time understanding why the alcoholic or drug abuser gets hooked, it is critical that physicians learn to look upon the condition as they would any other chronic — and potentially fatal — disease. According to Dr. Collins, 56 is the average life expectancy for an alcoholic, while the opiate abuser lives to an average of 37.

"We need to undo our own prejudices and to look beyond our own personal experiences," says Dr. Collins, because, "we are in a very pivotal position in terms of the chemically dependent person's disease." **OSMA.**

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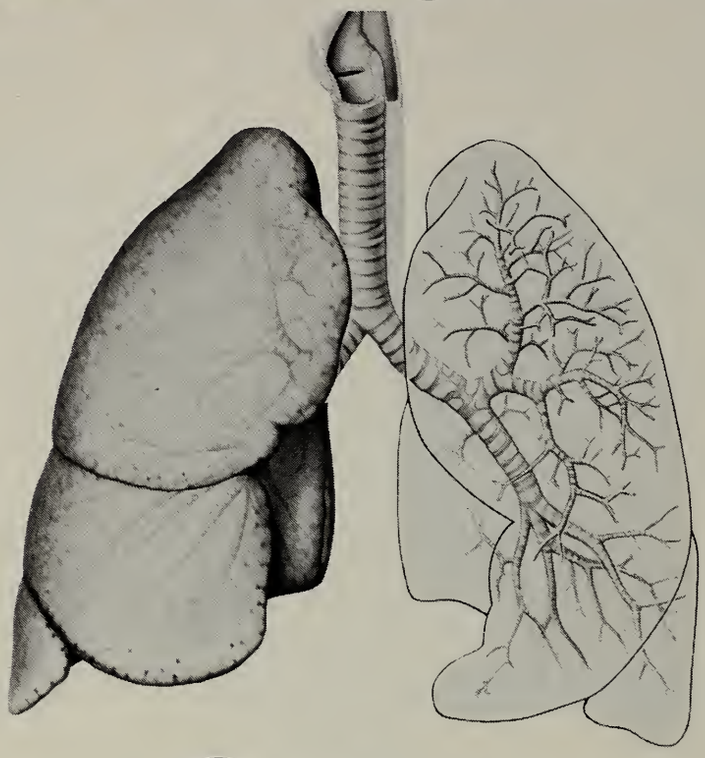
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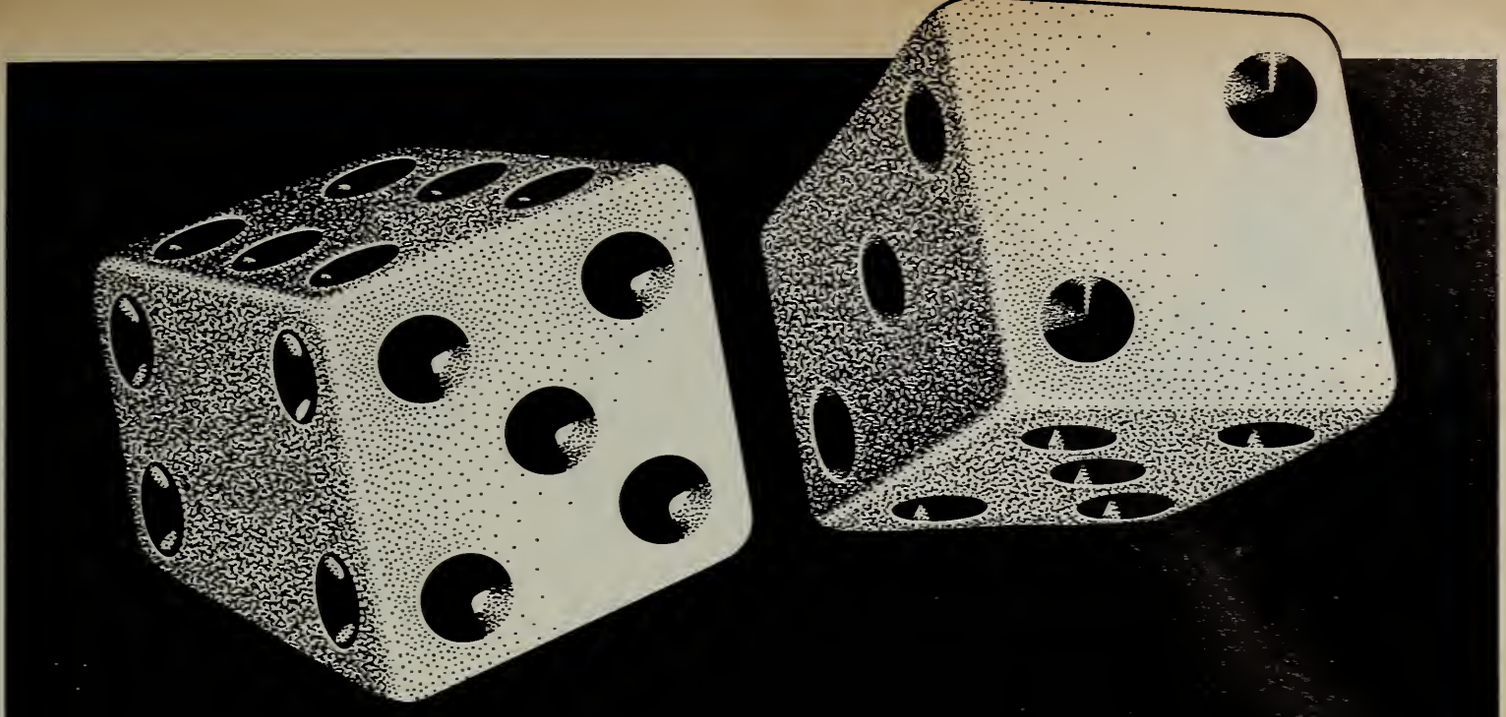
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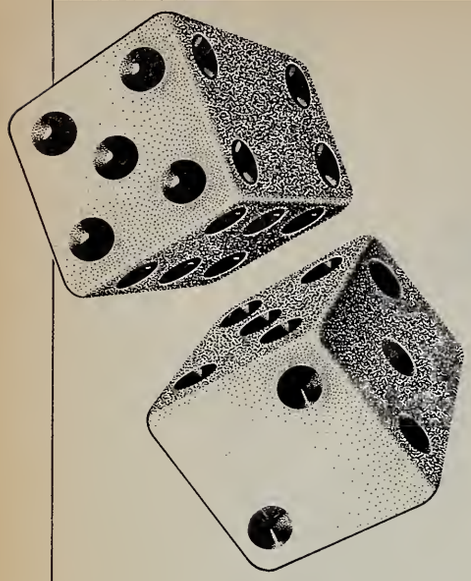
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The Gambling Addict:
Improving the odds for a cure

By Karen S. Edwards

It's the glitz . . . the glamour . . . the dice that rattle like dead men's teeth across green felt-topped tables. It's shiny, fast cards . . . the "sure thing" . . .action, so hard-edged and fast-paced your heart pounds like the hooves of racehorses thundering down the homestretch. It's the enticement of easy money . . . the sweet smell of success that teases and tempts as it whirls about you in an eternal, infernal dance. But *whatever* it is that's luring Americans into the world of compulsive gambling, there is no question that more and more people are being snared by this addiction each year.



Nationwide estimates put the compulsive gambling population somewhere between 4 and 12 percent. Here in Ohio, a study, commissioned by the Ohio Lottery, estimates that almost 2.5 percent of Ohio adults are addicted to gambling. In round numbers, that's approximately 200,000 pathological gamblers in the state.

But they are not all hanging around the track or those poker tables, euphemistically referred to as "sporting clubs." At least, not all the time. Many of them are working . . . as bank presidents, attorneys, stockbrokers, football players, policemen, firemen . . . some of them may even be sitting right there in your waiting room — but don't expect to find any obvious, characteristic qualities that will immediately draw your attention to them. They don't walk around with green-shaded visors on their heads, nor is there really such a thing as the "quintessential" pathological gambler.

Don't expect to find any obvious, characteristic qualities . . . they don't walk around with green-shaded visors on their heads.

"Every compulsive gambler is different," explains Bonnie Adkins, a social worker and certified alcoholism counselor who serves as Coordinator of the Gambling Treatment Center at the VA Hospital in Brecksville — currently the only Ohio hospital which treats gambling addictions. Adkins also serves as President of the Ohio Council on Compulsive Gambling (OCCG), a one-year-old educational resource group.

However, that is *not* to say that pathological gamblers don't share some characteristics, she continues.

"Compulsive gamblers are preoccupied with gambling — that's all they think about. When they are involved in it — even when they're talking about it, they're high. Their cognitive level is the same as if they were intoxicated," says Adkins.

"The compulsive gambler is the one who stays until the doors are closed," agrees Don — no last name — but he should know. A compulsive gambler for almost 20 years, Don is now recovering from his addiction. He's been "clean" since March 25, 1981, and now leads meetings of Gamblers Anonymous, a self-help group, patterned after the better-known (and Ohio-born) Alcoholics Anonymous.

Don's story is typical of many compulsive gamblers. He started with penny ante games in his youth, and by his teens was betting the horses at Scioto Downs, a harness racetrack in Columbus. His first bet there — $8 on a 19-to-1 spot — was quickly parlayed into $160.

"That's when I began to bet regularly," he says. "But I can't say *when* things got out of hand."

It was long before the state lottery, he says — but the lottery didn't help.

"When I bet on the horses, I had 100 nights of racing, and 200 nights to recover my money," he says. But, with the advent of the state lottery, Don found himself betting $50 a day, with no recovery time.

Still, he's quick to point out that he doesn't blame the state for his problem. "The state is in it (the lottery) as a business. They are not responsible for my sickness or the sickness of others," he says — presumably anymore than the state, with its tightly controlled liquor stores, can be blamed for alcoholism.

This sentiment is one that appears to be widespread — even among the state's compulsive

gambler population.

"There was very strong support from those interviewed for the Ohio Lottery survey that the state is *not* responsible for gambling addiction," says Paul H. Coleman, director of the Governor's Office of Advocacy for Recovery Services.

In final form, the report says the lottery is not likely to contribute significantly to gambling addiction because most pathological gamblers want the excitement of faster action and larger wages.

"I don't know a single compulsive gambler who is a winner," agrees Don. "They're in it for the action and the excitement. That's what they crave more than the money."

But Bonnie Adkins isn't sure that the state lotteries and other types of legalized gambling aren't making it easier for pathological gamblers to get started.

"The more you expose people to gambling, the more compulsive gamblers there are going to be. It's only logical," she says.

There are people, she points out, who never gambled until it suddenly became legal to do so.

"I know of a fireman in Atlantic City who never gambled until the casinos opened there. Once they did, he began to bet, and before long he was a compulsive gambler. Although he's now recovering, he's finding it difficult to abstain because of all the bright neon signs and other temptations that surround him," says Adkins.

But what that seems to prove, more than anything else, is that compulsive gamblers can always find tools with which to satisfy their addictions.

"Sure, we have lottery freaks, but we also have bingo freaks — they go around and buy up every card in the city," says Don.

All for that heady thrill which distinguishes the compulsive gambler from the one who can walk away.

"Some gamblers leave it for awhile. They go through periods of remorse and quit. They 'bail out' — a gambler's term for getting friends or family to pay you up. But they always go back," says Don.

They go back because gambling has become their whole life. To many, it is a way for them to feel important — "like big shots," says Don.

"Gamblers put on a 'big-shot image' that's really very different from the people they are. Usually, they're very private people — secretive, loner types," says Don — characteristics which often become crucial when you're dodging bill collectors, or trying to hide your habit from a spouse, he adds.

But this private, secret world eventually backfires.

"After awhile, you find you don't love anyone around you anymore . . . that you're the only person you care about," says Don.

Morals begin to disintegrate, and that's when the horror stories begin . . . the bank president who embezzles a quarter of a million dollars to play the lotto . . . the stockbroker who violates his client's trust — and money . . . the office worker who starts a "pool," then uses the money to place his or her own sports bets.

"Gamblers aren't people who can easily say "I'm sorry," notes Don.

So, caught in a morass of deceit and, often, illegal activity — shutting themselves off from the people who care about them —

"I don't know a single compulsive gambler who is a winner. They're in it for the action . . . that's what they crave."

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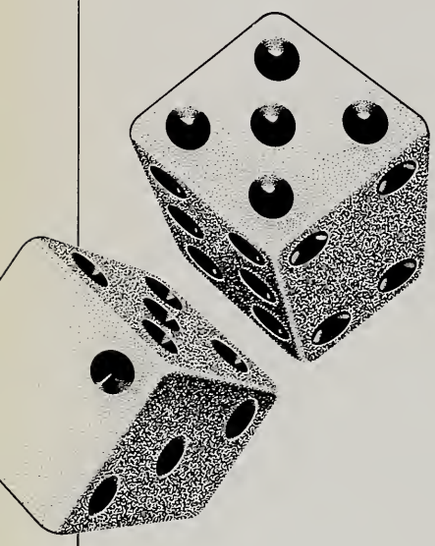
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the pathological gambler may turn to other types of compulsions for solace.

"My own problem is overeating," says Don — but it could just as easily be a compulsion to overwork, overspend or womanize.

"I won't say that some gamblers don't turn to other substances like drugs or alcohol. It can happen," says Don.

And, according to Adkins, it happens frequently.

"I would say 45 percent of the compulsive gamblers we admit are also addicted to alcohol," she says.

Some have other problems, not directly related to a specific compulsion.

"Gamblers will often have secondary problems, usually of an emotional or psychiatric nature. I would say we usually have at least one dual-diagnosed patient with each group."

But she's hesitant to say that the drugs, the alcohol — "the problems of an emotional or psychiatric nature" — are what drive these people to gamble.

"I don't like the phrase 'addictive personality,' " she says. "I think addiction is multi-causal. You can't put your finger on one thing or one personality type and say 'this causes addiction.' "

Instead, she says, there are numerous factors which can bring on a gambling compulsion.

"It could be cultural. The Lebanese, for example, gamble because that's what their men do — it's considered very macho. Or it could be the peer pressure group they're exposed to, or the way these particular individuals handle stress. Or it could be a learned behavior from parents, family or friends," she says.

As with alcohol and drug addiction, research is also being done on the brain's neurotransmitters — to see whether or not compulsive gamblers have inherited a predilection for their problem.

"There are many reasons why people start to gamble, just as there are many different types of gamblers. When diagnosing this group, you really must be careful to use a differential diagnosis," Adkins cautions.

What kinds of things should you look for when diagnosing a compulsive (as opposed to a non-compulsive) gambler? If you hope to have him or her admitted to one of the six beds which the VA Hospital in Brecksville allocates out of its 52-bed alcoholism unit for compulsive gamblers, there are several criteria your patient must meet.

First, he or she must be a veteran. If the patient is not, you should make yourself familiar with the eight or nine *other* treatment facilities in the country — all of which are private, and most of which are centered on the east coast — Maryland, New York, Connecticut, New Jersey, Pennsylvania.

Then, once you've located a facility, Adkins says to look for the following:

"Loss of control. Compulsive gamblers are people who no longer have the ability to stop gambling on their own. They need help to stop.

"Second, the problem should be chronic and long-term. Finally, look for signs of destruction in their personal lives. That destruction could be financial, legal, family or vocational," she explains.

This admission criteria is among the DSM III criteria recommended by the American Psychiatric

There are many reasons why people start to gamble, just as there are many types of gamblers. When diagnosing this group, you must use a differential diagnosis.

Institute (API), yet it wasn't until 1980 that the API even recognized compulsive gambling as a mental health problem.

Treatment, too, has developed at a snail's pace. In fact, the first efforts in this area were made by two laymen — two compulsive gamblers from Los Angeles who "were probably familiar with the structure of an AA meeting," says Don. These were the two who, in September of 1957, organized the first Gamblers Anonymous.

For every Gamblers Anonymous member we have who has stayed, we have many more who have gone away.

But the Ohio medical community wasn't exactly setting on its heels — at least not in Brecksville, where, in 1972, a psychiatrist by the name of Robert Custer, MD, was working on the VA Hospital's alcoholism unit. It was Dr. Custer who eventually developed the treatment program for gambling addicts which is used at the hospital today, and serves as a model for other treatment facilities. It was also Dr. Custer, says Adkins, who was instrumental in the API's recognition of gambling addiction as an illness.

"For a long time, though, we were the first and only treatment center for compulsive gambling in the U.S.," she adds.

Treatment is, as might be expected, very similar to that used for alcoholics.

"We use group therapy because it provides more feedback and also because it's more difficult for a participant to manipulate a group than a one-on-one counselor. These people are great manipulators, but usually the group can see right through them — sometimes when the professional can't," Adkins explains.

By helping the others in the group, the participants are also able to develop a sense of self-esteem — which is traditionally low in these addicts. That's why compulsive gamblers crave that "big-shot" image.

"I also have them write an autobiography which they deliver, orally, to the group," she says. Not only does this inform the group about the various participants, but it also helps the gambler "keep the past in the past," says Adkins.

There is also psychological testing; patient education, accomplished through lectures, films and books; assertiveness training; relaxation classes; and stress management.

"Patients also go to three GA meetings a week here at the hospital."

Conference calls to family members and friends keep the patient in touch with home during his or her 30-day stay. "Patient stays are reimbursed by insurance companies in states where gambling addiction is recognized as an illness," explains Adkins. Otherwise, the problem is often listed as "depression" so that treatment will be covered.

Two follow-up studies, conducted by the hospital, show that the program's success rate is very high.

"After one year, 54 percent of our patients report total abstinence from gambling. If you include those who had a brief relapse, and then abstained, that total would climb to 72 percent," says Adkins.

Unfortunately, says Don, Gamblers Anonymous can't make the same claims.

"For every GA member we have who has stayed, we have many more who have gone away," he says. But there are reasons for that.

"We get the people who walk in off the street when the chips are down and expect us to wave our

booklet at them and cure them. But it doesn't happen that way. There is no cure."

Or times get better, and the people move on.

"Usually when they come to us, they've hit bottom. Maybe someone — their spouse or their boss — has stuck an ultimatum to them — 'go or else.' So they come, but we know, once their conditions improve, they'll move on. They don't really want to quit."

But wanting to quit is the primary prerequisite for GA members.

"It's OK if they slip. We just change their anniversary date and go back to square one. There is no shame there," says Don.

Yet it's that desire to quit that makes a successful member. "I knew I had to quit when I saw that my morals were disintegrating," says Don. "I was trying to raise a family with good morals, then, there I was, being dishonest — cheating. I never did anything illegal, but I knew if I kept going the way I was going, I might have done."

According to Don, it's that kind of honesty and openness — not only with themselves, but with others — that will determine a GA member's success.

"Members must be willing to work at their problem. They must attend meetings and speak up," says Don.

Although GA meetings differ from area to area, most are conducted like group therapy sessions, where everyone has a chance to have his or her say.

"GA has no 'staff.' Anyone who has a 90-day abstinence record is entitled to lead a group. But we're all equals. All suggestions that are made or topics that are raised are valid items for discussion. We don't criticize or judge," says Don.

At the end of the meeting, phone numbers are exchanged.

"Any member has the right to call any other member — any time of the day or night — if a gambling urge occurs," says Don.

"The self-help groups, like GA and Gam-Anon, for family members of gamblers, are vitally important," says Adkins.

Yet they are growing very slowly — "except in New Jersey where, thanks to the casinos, they're proliferating," quips Adkins.

Still, she admits that there is a long way to go in educating the public about this problem.

"OCCG is one solution. We are a group of concerned citizens who formed together one year ago, for the purpose of bringing attention to the gambling problem, and letting the public know it is a treatable disease," says Adkins. "Many people don't even know there is a problem," she adds.

One such person was Governor Richard Celeste, who discovered the problem while touring the state in his "capital for a day program" last year. He was tossed a hard-hitting question on the subject, and fielded it right into his office of Advocacy for Recovery Service — the one headed by Coleman.

"The Governor felt that the overall cost of compulsive gambling is so great in our state — not only in terms of dollars and cents, but in shattered lives — that Ohio has a moral responsibility and obligation to be part of the solution to the compulsive gambling problem," he says.

While the dollar figure Coleman alludes to doesn't begin to approach the dollar figure estimated for alcohol and drug abuse, it's a hefty sum, nevertheless — about $34 million nationwide, according to a report commissioned by the Colorado Lottery and completed by the Washington Center for Pathological Gambling. That includes lost worker productivity, crime, court costs and social service programs. (For alcohol and drug abuse, that figure adds up to $176 billion.)

But Ohio is one of six states which has become actively involved in funding programs for the prevention, education and treatment of gambling addiction.

"We join with Maryland, Connecticut, New York, New Jersey and Minnesota, on the cutting edge of the problem," says Coleman.



Ohio's program, which will be introduced this month and phased in over a period of time is *not* being funded from lottery profits, Coleman is quick to emphasize.

"Those profits have been earmarked for the schools from the beginning. That's where they should go, and that's where they're going," he says.

Instead, dollars for the program will come from the money that has already been allocated for advertising.

"Some of these funds will be used to pay for a statewide, toll-free telephone line which people can call for assistance with gambling problems," says Coleman. Callers will be directed to different referral sources — GA, mental health centers, outpatient clinics. Coleman hopes to have the number printed on lottery brochures and have it run across the bottom of those television commercials which promote the state lottery.

"We also hope to launch a public information campaign that will make people aware of the warning signs of problem gambling," he adds.

The program's third thrust will be toward the schools — both elementary and secondary.

"The state of knowledge in our schools — at least concerning gambling addiction — is where it was 30 or 40 years ago. We need to get into the schools with programs that will update them on the consequences of such life-wrecking choices as playing games for money," says Coleman.

Education and prevention are obviously the most cost-efficient ways for the state to become involved with the problem.

"Of course, more treatment centers are needed — but that is an area that's better run by sectors other than the state government," Coleman explains.

Whether or not more treatment centers pop up in the next year or two "is really a marketplace question," he adds.

"If the market develops a need for these centers, then we'll probably see more," he says. He assumes the most likely move will be by hospitals converting their general-surgical beds over to gambling patients.

"There is no question that gambling is a substance abuse. The substance abused is money."

"There is no question that gambling is a substance abuse. The substance abused is money," Coleman points out. But he says because there is no real physical danger with gambling addiction the way there is with other substance abuse, "I am probably a little less concerned about there being enough hospital beds for this type of addiction."

Besides, he is hoping the state's new program will nip any gambling problems *before* they develop.

But Don and Bonnie Adkins and their colleagues are ready and willing to help in the rehabilitation process if and when gambling addiction problems occur.

"The wonderful thing about gambling addicts is that they are usually very intelligent, very skilled people," says Adkins. "Once they are rehabilitated, they make a very good contribution to society." That's why she can often be seen scratching out a letter to the courts on behalf of a gambler — pleading for rehabilitation through a treatment center or GA — in lieu of a prison sentence.

"Jail won't help them — but we can," she says. **OSMA**

Karen S. Edwards is the Executive Editor of the **Ohio State Medical Journal.**

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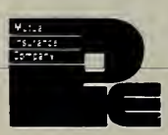
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Before You Test a Patient for AIDS...

Ohio Department of Health Recommendations for Clinical Management of Individuals with HTLV-3 Infection

I. Indications for Testing

A. Background

1. Before testing an individual's serum for HTLV-3 antibody, that person should be informed of the intention to test, and the implications of a positive and negative test should be discussed. It is recommended that physicians obtain patient consent before proceeding with the test. Written consent should be considered. If these conditions cannot be adequately met, the physician should refer the individual to an HTLV-3 Antibody Education and Alternate Test Site for testing and counseling. Further information on these centers can be obtained by calling (800) 332-AIDS.

   There are now well documented instances of individuals losing employment and life insurance as well as other forms of social stigmatization following disclosure of results of their serologic status to HTLV-3. Once the result is placed in the patient's chart, it is no longer a totally confidential finding, as it would be released to insurance companies or employers as part of a general medical release authorized by the patient. Furthermore, in high risk individuals it has been clearly documented that disclosure of serologic results may result in significant depression and suicidal thinking. It is now agreed by most authorities that prior to performing the test on any individual, the risks and benefits must be explained.

2. The ELISA test for HTLV-3 antibody is a very sensitive test for screening donated blood. However, when the test is used to detect HTLV-3 infection in an individual, results must be interpreted cautiously. When applied to a person at high risk of having been exposed (for "high risk" populations, see below), a positive test should be interpreted as indicating HTLV-3 infection. However, when applied to the general population, almost all positive tests appear to be false-positives; that is, "low risk" individuals with positive tests most likely have *not* been infected (or individuals are not truly "low risk").

3. A second test which is more specific, through less sensitive, for HTLV-3 infection can be performed using the Western Blot technique. It is more expensive and less widely available than the ELISA test. Individuals with low risk of exposure, on whose serum the ELISA test is positive and Western Blot test is negative, probably have not been infected. Conversely, this combination of test results may represent false negativity of the Western Blot test in individuals from high risk groups.

B. When and how to use the HTLV-3 antibody test to determine if a person is infected with the virus

1. Establish the risk group
   a. High-risk individuals are:
      i. homosexual and

bisexual men
ii. hemophiliacs
iii. intravenous (IV) drug users
iv. prostitutes who use IV drugs
v. sex partners of high risk individuals
vi. sex partners of persons with AIDS or persons known to be HTLV-3 positive
vii. fetuses and newborn children of parents with AIDS or HTLV-3 infection or parents at risk for AIDS
viii. those persons born in or recently emigrated from countries where there is a high incidence of AIDS

b. Individuals who are not represented above are considered *low risk* for HTLV-3 infection.

2. Pre-test counseling
   a. Because behavioral changes are recommended for both HTLV-3 infected and non-infected individuals in *high risk* groups, ODH believes that persons in the *high risk* groups may benefit from being tested when confidentiality can be assured. If strict confidentiality cannot be assured, these individuals should be referred to an Alternate Test Site.
   b. Individuals with *low risk* of infection should not be routinely tested.
3. Test result interpretation for high risk groups
   a. A strongly reactive (positive) ELISA result (ratio of patient's result to cut-off ≥ 7.0 by the Abbott test or ≥ 2.0 by the Litton test; this should be obtained from the laboratory performing the test) in a person from a high risk group probably indicates infection with the virus. No Western Blot testing is necessary.
   b. Interpretation of weakly reactive ELISA results (ratio < 7.0 by the Abbott test or < 2.0 by the Litton test) in high risk persons is less certain. A Western Blot test should be performed.
      i. Persons with a weakly reactive ELISA test and a positive Western Blot should be managed as though HTLV-3 infected.
      ii. Test results of persons with a weakly reactive ELISA test and a negative Western Blot should be considered indeterminate. These persons should be retested in 60 days and counseled on "safe sex."
4. Test result interpretation for low risk individuals
   a. If persons from low risk groups are found to have a reactive test, their risk status should be reassessed. If they are still found to be at low risk of HTLV-3 infection, the ELISA should be repeated on a different blood sample.
   b. If the repeated test is negative and the patient has no unexplained illness, he/she can be considered to be non-infected.
   c. If the repeated ELISA test is reactive, a Western Blot test should be performed. If the Western Blot is negative, the person should be considered non-infected. If the Western Blot is positive, the person should be considered HTLV-3 infected.

II. Follow-up of Individuals with NONREACTIVE tests.

A. In **low risk individuals,** reassure the patient that there is no evidence of HTLV-3 infection.

B. In **high risk individuals,** counsel the individual regarding changes in behavior to reduce the possibility of future exposure to HTLV-3.

III. Management of patients infected with HTLV-3.

A. Complete history and physical examination. Particular attention should be paid to the following:
1. Symptoms of persistent fever or night sweats, weight loss, memory loss or personality change, persistent respiratory symptoms, dysphagia or esophageal pain, persistent diarrhea.
2. Examination of the oral cavity, looking for mouth ulcers, hairy leukoplakia, candidiasis, tongue papules, ulcers or violaceous macules.
3. Careful examination of the eyegrounds for evidence of retinitis (hard or soft

HTLV-3 TESTING PROGRAM LABORATORIES

OHIO

1) Medical College of Ohio
C.S. No. 10008
Toledo, Ohio 43699
Contact: Dr. Earl Freimer
CC: Ann Donabedian

2) Hoxworth Blood Center
University of Cincinnati Medical Center
3231 Burnet Avenue
Cincinnati, Ohio 45267-0055
Contact: Dr. Kay Zelenski

3) Cleveland Clinic Foundation
9500 Euclid Avenue
Cleveland, Ohio 44106
Contact: Max Proffitt, PhD

4) Aultman Hospital
2600 Sixth Street, S.W.
Canton, Ohio 44710
Contact: John Thomas, PhD

5) Columbus City Health Department
Ollie M. Goodloe Health Center
181 South Washington Blvd.
Columbus, Ohio 43215
Contact: Mike Smeltzer

exudates, hemorrhages).
4. Examination of all lymph nodes, liver and spleen.
5. Total body skin exam for Kaposi's sarcoma. Suspicious violaceous macules or papules should be biopsied.
6. Careful neurologic examination including mental status evaluation.
7. Careful anal exam for evidence of proctitis or perianal lesions.

B. Recommended **laboratory tests** for all individuals infected with HTLV-3. Items 1-5 should be done to establish a baseline on all patients whether symptomatic or not.
1. CBC, with white cell differential and platelet estimate.
2. Serologic test for syphilis.
3. Hepatitis B surface antigen and core antibody.
4. Liver function profile (Alkaline phosphatase, SGOT, SGPT, bilirubin, albumin).
5. Tuberculin skin test
6. Evaluation of functional immune status (optional):
   a. Skin test anergy testing to multiple antigens.
   b. Evaluation of T cell subsets.
   c. Note: Skin tests and the absolute number of T "helper" cells may have prognostic value. However, these tests are expensive, and the predictive value of a single test is limited. Repeated testing of immune function will be quite expensive and may be of limited value in relation to the cost for the individual patient.

FOR PERSONS WHOSE RESULTS FROM THE ABOVE EVALUATION INDICATE THE POSSIBILITY OF AIDS OR ARC, YOU MAY ELECT TO CONSULT WITH OR REFER THE PATIENT TO A CLINICAL SPECIALIST FAMILIAR WITH AIDS RELATED DISORDERS. A list of medical, social and psychosocial services and providers in your area is available by calling the Ohio AIDS Hotline at 1-800-332-AIDS.

C. HTLV-3 infected patients with abnormalities detected by history, physical or laboratory results may require extensive additional investigation. There are many complications of HTLV-3 infection, some caused by HTLV-3 virus itself and others caused by opportunistic infections and/or neoplasms. Some of the more common complications include:
1. **Generalized lymphadenopathy.** This is often associated with HTLV-3 infection alone, but consideration must be given to other lymphadenopathy producing diseases such as EBV and CMV mononucleosis, toxoplasmosis, syphilis, and lymphoma.
2. **Stomatitis and esophagitis.** Chronic herpes simplex and Candida albicans infections are the most common causes.
3. **Enteritis and proctitis.** Agents may be common enteric bacterial pathogens, sexually transmitted diseases such as herpes simplex or gonorrhea, and/or parasitic pathogens such as amoeba, giardia, and cryptosporidiosis.
4. **Kaposi's sarcoma.** Skin lesions may be subtle, or lesions may occur only on mucous membranes.
5. **Interstitial Pneumonitis.** The most common cause is **Pneumocystis carinii,** but tuberculosis, non-tuberculous mycobacterial infection, CMV pneumonitis and many others are possible.
6. **Ophthalmitis.** Caused by HTLV-3 or CMV.
7. **Various alterations in neurologic function.** Caused by HTLV-3 infection of the brain or cord, by opportunistic infections, or CNS lymphomas.

D. Infection prevention
1. Review vaccination status of routine childhood immunizations and update as appropriate, avoiding live virus vaccines (measles, mumps, rubella and polio).
2. Administer pneumococcal vaccine.
3. Administer yearly influenza

HTLV-3 Alternate Testsites

Ohio

1) Medical College of Ohio
C.S. No. 10008
Toledo, Ohio 43699
Contact: Dr. Earl Freimer
CC: Ann Donabedian

2) Akron City Health Department
177 South Broadway
Akron, Ohio 44308-1799
Contact: Don Manson

3) Canton City Health Department
City Hall, 3rd Floor
218 Cleveland Avenue, S.W.
Canton, Ohio 44702
Contact: Robert Pattison, MPA

4) Cleveland City Health Department
Mural Building
1925 St. Clair Avenue
Cleveland, Ohio 44114
Contact: V. Diana Richardson, MD

5) Cincinnati City Health Department
3101 Burnet Avenue
Cincinnati, Ohio 45229
Contact: Michael Ritchey

6) Montgomery County Health Department
County Government Plaza
P.O. Box 972
451 West Third Street
Dayton, Ohio 45422
Contact: Larry Krumm

7) Columbus City Health Department
Ollie M. Goodloe Health Center
181 South Washington Blvd.
Columbus, Ohio 43215
Contact: Mike Smeltzer

vaccine.

4. Administer hepatitis B vaccine if core antibody negative.
5. If tuberculin test is positive, evaluate for active tuberculosis and consider isoniazid prophylaxis.

E. Counseling. HTLV-3 infected individuals should understand the following:

1. About two-thirds of infected persons remain asymptomatic, at least for the four to five years they have been observed. At present it appears that over five years approximately 10% of HTLV-3 infected patients have developed AIDS (most commonly defined as evidence of HTLV-3 infection, *plus* an opportunistic infection or neoplasm). Approximately 25% of infected individuals appear to develop other health problems such as chronic lymphadenopathy and may be clinically well, mildly ill or quite ill.
2. Even though asymptomatic, persons with HTLV-3 infection can transmit their infection to others through sexual intercourse or exposure to blood. No other routes of infection have been demonstrated. Casual contact in the school, workplace, or even in the home does not present a risk of transmission.
3. Patients who have been infected with HTLV-3 should be counselled to alter their behaviors to minimize the possibility of transmission. Sexual abstinence, monogamous relationships, and/or sexual activities which prevent the exchange of body fluids are some general recommendations. Safe sexual practices *must* be adopted.
4. Toothbrushes, razors, needles, and other instruments which could transmit blood should not be shared.
5. Patients infected with HTLV-3 should advise medical and dental practitioners that their blood is considered infectious so that proper precautions can be taken.
6. Persons infected with HTLV-3 should not donate blood, plasma, body organs, or semen.
7. Women of child-bearing age with HTLV-3 infection can transmit the infection to the fetus and newborn infants and should be so advised.
8. Persons infected with HTLV-3 should so inform their sexual and/or needle sharing contacts so that these contacts may seek testing and counseling. (Suggest that contacts be referred to Alternate Test Sites.)

F. Reporting AIDS patients. AIDS and ARC are legally

ARC is now reportable in Ohio

Physicians treating patients with Aids Related Complex (ARC), the condition which frequently precedes the full-blown Acquired Immunodeficiency Syndrome, must now report these cases to the local health department. The Public Health Council added ARC to Ohio's list of class A legally reportable conditions in January, and it became effective in late March. AIDS has been a reportable condition in Ohio since October 1983.

While a specific case definition has not been published for ARC, a surveillance definition has been developed by the Ohio Department of Health for reporting purposes. ARC is thus defined as any person having:

1. At least three of the following clinical signs/symptoms lasting three or more months, and unexplained by other illnesses or conditions:
   - A fever over 100 degrees F, either intermittent or continuous
   - Weight loss of 10 percent or equal or greater to 15 pounds
   - Lymphadenopathy
   - Diarrhea, either intermittent or continuous
   - Fatigue, to the point of decreased physical or mental function
   - Night sweats, either intermittent or continuous
   - Established central or peripheral neurologic deficit
   - Idiopathic thrombocytopenia purpura (ITP)
   - Oral Candidiasis
2. A positive serologic test for identification of antibodies to HTLV-III or a positive culture for the HTLV-III.

In a position paper put out by the Ohio Department of Health, however, the department warned that the HTLV-III antibody test not be used to screen the general population or to mass screen captive populations such as school children or those institutionalized.

"AIDS and infection with the AIDS' HTLV-III antibody test will falsely identify many individuals as 'carriers' of the AIDS virus when they actually do not have such an infection," the paper states. "This false test can have a devastating effect on an individual who in reality is perfectly healthy."

However, the antibody test has proven valuable in evaluating an individual patient who has symptoms of AIDS or AIDS Related Complex. Still, "the HTLV-III antibody test should only be performed with the individual's informed consent," say the Health Department's guidelines. "Adequate information must be shared with the patient so he/she understands both the value and limitations of the test for the specific circumstances."

Doctors treating patients with ARC or AIDS must report these cases to the local health department of the patient's residence. This report may also be made to the local health department where the physician or hospital is located. These reports will then be forwarded to the Ohio Department of Health, Division of Epidemiology. — *Susan Porter*

reportable conditions in Ohio. The physician making the diagnosis is ultimately responsible for reporting. Cases should be reported to the Local Health Department which will in turn forward the report to the Ohio Department of Health. Every effort should be made at each step of the reporting process to maintain and protect the patient's confidentiality.

G. For more information

1. About this document — contact the Ohio Department of Health, Division of Epidemiology (614) 466-0265.
2. About local resources and consulting physicians — call the Ohio AIDS Hotline, toll-free at 1-800-332-AIDS.
3. About reporting requirements — contact your local health department.

For further information, contact the Ohio Department of Health, 246 N. High St., Columbus, Ohio.

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The 1986 Annual Meeting Proceedings of the OSMA House of Delegates

Minutes of the First Session

The first session of the House of Delegates of the Ohio State Medical Association was convened at 7:25 PM, Friday, May 2, 1986, at the Dayton Convention Center, with the President, Herman I. Abromowitz, M.D., presiding.

Dr. Abromowitz introduced Hart F. Page, CAE, past executive director, and asked the members of the House to rise while Mr. Page led them in giving the Pledge of Allegiance.

The invocation was offered by Father Thomas J. Diehl, St. Xavier Church, Cincinnati.

Dr. Abromowitz asked the House to remain standing and to observe a moment of silence in memory of Mrs. Nora Price, wife of Thomas Price, 9th District Councilor, who passed away Saturday, April 26.

Dr. Abromowitz then introduced others seated at the Speakers Table, as follows: Drs. John E. Albers, Cincinnati, President-Elect; A. Burton Payne, Ironton, Immediate Past President; Joseph Sudimack, Jr., Warren, Secretary-Treasurer; W.J. Lewis, Dayton, OSMA Parliamentarian; Messrs. Herbert E. Gillen, Executive Director; D. Brent Mulgrew, J.D., Managing Director, and Dr. Blaine L. Block, Dayton, President, Montgomery County Medical Society.

Dr. Block welcomed the delegates, alternates and guests to Dayton, on behalf of the Montgomery County Medical Society.

Report of the Credentials Committee

Dr. Luther W. High, Millersburg, Chairman of the Credentials Committee, reported that of 238 members eligible to attend and vote, 172 were present. This figure included 11 specialty society delegates who qualified for representation under Chapter 4, Section 3 of the OSMA Bylaws. The Medical Student and the Hospital Medical Staff Sections also were represented.

A number of alternate delegates, guests, officers of county medical societies, and executives were in attendance.

1985 Minutes Approved

The minutes of the 1985 sessions of the House of Delegates, as published in the August 1985 issue of the Ohio State Medical Journal, were approved by official action.

Introduction of AMA Vice Speaker

Dr. Abromowitz introduced Dr. John Lee Clowe, Schenectady, New York, Vice Speaker of the AMA House of Delegates and AMA Board Member. Dr. Clowe addressed the House.

Introduction of OSMA Past Presidents

Dr. Abromowitz introduced the following Past Presidents of the Association: Dr. Charles L. Hudson, Cleveland; Dr. Theodore L. Light, Dayton; Dr. Robert N. Smith, Toledo; Dr. Oscar W. Clarke, Gallipolis; Dr. James L. Henry, Grove City; Dr. John J. Gaughan, Cleveland; Dr. Thomas W. Morgan, Gallipolis; Dr. Robert G. Thomas, Elyria; Dr. Stewart B. Dunsker, Cincinnati; and Dr. S. Baird Pfahl, Jr., Sandusky.

Introduction of Past Members of the OSMA Council

Dr. Abromowitz then introduced former members of the Council: Dr. David A. Barr, Lima; Dr. Theodore J. Castele, Cleveland; Dr. Alford C. Diller, Van Wert; Dr. William Dorner, Jr., Akron; Dr. Philip B. Hardymon, Columbus; Dr. Edward G. Kilroy, Cleveland; Dr. W.J. Lewis, Dayton; Dr. C. Edward Pichette, Youngstown; and Dr. J. Hutchison Williams, Columbus.

PICO REPORT

Dr. John J. Gaughan, Cleveland, Chairman of the Board of the Physicians Insurance Company of Ohio, was introduced. Dr. Gaughan gave a report on the 1985-86

achievements of the company and reported on future activities.

OMERF Report

Dr. Oscar W. Clarke, Chairman of the Board of the Ohio Medical Education and Research Foundation, was introduced. Dr. Clarke gave a progress report on the Foundation and asked for the support of OSMA members.

Membership Outreach Program

Dr. Thomas W. Morgan, Gallipolis, Chairman of the OSMA Membership Committee, presented the results of Ohio's Physician Outreach Program — 1985 and announced the First and Second Place award winners and presented awards to the Third Place winners. He also announced the counties with 100% membership.

Introduction of OSMA Auxiliary President

Mrs. Diana H. Talmage, Toledo, Immediate Past President of the Ohio State Medical Association Auxiliary, was escorted to the rostrum by Dr. Lance Talmage. She addressed the House of Delegates and reported on 1985-86 activities of the Auxiliary.

Mrs. Talmage received a standing ovation of the House.

Presentation of AMA-ERF Checks

Dr. Philip B. Hardymon, Columbus, Chairman of Ohio's Committee for the American Medical Association's Education and Research Foundation (AMA-ERF) was introduced. Mrs. Myrna Tismo, Ironton, Chairman of the Auxiliary AMA-ERF Committee for Ohio, was escorted to the rostrum by David W. Pennington. Mrs. Talmage and Mrs. Tismo assisted Dr. Hardymon in the presentation of the checks to Ohio's six medical schools. The contributions totaled $92,216.50.

Certificates of Appreciation to Retiring Members of The Council

The following members of the Council received certificates of appreciation in honor of their service to the Association as members of the Council: Drs. A. Burton Payne, Ironton; David A. Barr, Lima, and Judith Lavrich, Cincinnati.

Drs. Benjamin H. Reed, Wauseon, D. James Hickson, Mt. Gilead and Carl E. Spragg, New Concord, who were not in attendance, will also receive certificates of appreciation.

Certificates of Appreciation

Dr. Abromowitz presented certificates of appreciation to the following retiring chairmen of Standing and Special Committees: Dr. Homer A. Anderson, Columbus, Chairman of the Committee on Judicial and Professional Relations; Dr. Jerry L. Hammon, Dayton, Chairman of the Committee on Program; Dr. Philip B. Hardymon, Columbus, Chairman of the Committee on AMA-ERF; Dr. Edmund C. Casey, Cincinnati, Chairman of the Committee on Health Manpower; Dr. Edward E. Grable, Canton, Chairman of the Committee on Maternal and Neonatal Health; Dr. Paul S. Metzger, Columbus, Chairman of the Committee on Medical Health Care Issues; and Dr. J. Hutchison Williams, Columbus, Chairman of the Medical Student Advisory Committee.

Dr. Abromowitz announced the names of the retiring members of Standing Committees and advised that they would receive their certificates of appreciation at a later date.

Reference Committee Chairmen Announced

The following House of Delegates Reference Committee chairmen were introduced by President Abromowitz: Credentials of Delegates — Dr. Luther W. High, Holmes County; Tellers and Judges of Election — Dr. Claire V. Wolfe, Franklin County; Resolutions Committee No. 1 — Dr. Theodore J. Castele, Cuyahoga County; Resolutions Committee No. 2 — Dr. Roland A. Gandy, Jr., Lucas County; Resolutions Committee No. 3 and President's Address — Dr. Walter A. Reiling, Jr., Montgomery County.

Dr. Abromowitz also announced some changes in committee personnel.

Election of Committee on Nominations

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations: First District — Dr. S. Marcus Wigser, Hamilton County; Second District — Dr. A. Robert Davies, Miami County; Third District — Dr. Alford C. Diller, Van Wert County; Fourth District — Dr. Richard J. Wiseley, Lucas County; Fifth District — Dr. John J. Gaughan, Cuyahoga County; Sixth District — Dr. Robert C. Reed, Stark County; Seventh District — Dr. Daniel Clemens, Tuscarawas County; Eighth District — Dr. John W. Ray, Muskingum County; Ninth District — Dr. Oscar W. Clarke, Gallia County; Tenth District — Dr. Paul S. Metzger, Franklin County; Eleventh District — Dr. Jon H. Cooperrider, Ashland County; Twelfth District — Dr. Donald A. Hammel, Portage County.

Dr. Abromowitz announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the Committee this year would be the delegate from the First District, Dr. S. Marcus Wigser, Hamilton County.

President's Address

Herbert E. Gillen introduced Dr. Herman I. Abromowitz, who then gave his Presidential Address.

Upon completion of the presentation of the Address, Dr. Abromowitz received a standing ovation.

Introduction of Out-of-State Guests

Dr. Abromowitz introduced the following out-of-state guests: Dr. Paul Siebenmorgen, Terre Haute, Indiana, President of the Indiana State Medical Association, and Mrs. Siebenmorgen; Dr. Wally O. Montgomery, Paducah, Kentucky, President of the Kentucky Medical Association, and Mrs. Montgomery; Dr. David Z. Morgan, Charleston, West Virginia, President of the West Virginia State Medical Association, and Mrs. Morgan; and Dr. John P. Mullooly, Milwaukee, Wisconsin, President-Elect of the Wisconsin Medical Society, and Mrs. Mullooly.

Introduction of Representatives of Allied Organizations

Dr. Abromowitz introduced the following representatives of allied organizations: L. Thomas Wilburn,

Cincinnati, Chairman of the Board, Ohio Hospital Association; Dr. Mary Beth Strauss, Columbus, President, Ohio Nurses Association; Forrest E. Pack, Cincinnati, President, Ohio State Pharmaceutical Association, and Mrs. Pack; Mrs. Gloria Jordan, L.P.N., Dayton, President, Licensed Practical Nurses Association, and Mr. Jordan; Leslie W. Jacobs, Esq., Cleveland, President-Elect, Ohio State Bar Association; Dr. Leonard Tinney, Dublin, First Vice President, Ohio Veterinary Medical Association, and Mrs. Tinney; Marilyn Stinehart, CMA, Fostoria, President, Ohio State Society of Medical Assistants; Mrs. Joyce Johnson, Columbus, President-Elect, Ohio State Medical Association Auxiliary, and Dr. Johnson.

Memorial Resolutions Introduced

The following Memorial Resolutions were presented to the House:

George T. Harding, III, M.D.

Read by Dr. H. William Porterfield, Franklin County, Tenth District Councilor.

WHEREAS, George T. Harding, III, M.D., born in Columbus, Ohio, May 27, 1904, served as Councilor of the Ohio State Medical Association, 1942-1945; and

WHEREAS, Dr. Harding served as President of the Ohio Psychiatric Association, and received the Distinguished Service Award; and

WHEREAS, Dr. Harding was the Medical Director of Harding Hospital for 39 years, and was instrumental in developing innovative services for the state's mental health program; and

WHEREAS, Dr. Harding was the President of the Columbus Academy of Medicine in 1944-1945; and

WHEREAS, Dr. Harding was an Emeritus Clinical Professor of Psychiatry at the Ohio State University, and was a Fellow of both the American Psychiatric Association and the American College of Physicians; and

WHEREAS, Dr. Harding, after this long and distinguished career, died on November 22, 1985; therefore be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association recognizes the contributions Dr. Harding has made to the profession of medicine, and observes with sadness the death of this vigorous and accomplished colleague; and, be it further

RESOLVED, That a memorial resolution be introduced by the Ohio Delegation at the Annual Meeting of the American Medical Association House of Delegates.

Warren W. Smith, M.D.

Read by Dr. H. William Porterfield, Franklin County, Tenth District Councilor.

WHEREAS, Warren W. Smith, M.D., served his community faithfully and well during his 37 years as a physician; and

WHEREAS, Dr. Smith exemplified the highest traditions of the medical profession in his practice; and

WHEREAS, Dr. Smith served for many years as editor and as a member of the editorial advisory board of *The Bulletin* of the Academy of Medicine of Columbus and Franklin County — winning highest respect from colleagues and staff, alike, in this capacity; and

WHEREAS, Dr. Smith represented the Academy in the Ohio State Medical Association House of Delegates for several years, and served on the editorial board of the *Ohio State Medical Journal;* and

WHEREAS, Dr. Smith was ever-concerned with vital social issues that affected physicians and patients — and never hesitated to offer constructive, compassionate advice in open forum for the ultimate benefit of all concerned persons; therefore be it

RESOLVED, That the Ohio State Medical Association expresses its sincere appreciation and admiration for Dr. Smith's many contributions during his lifetime, and extends its deepest sympathy to Mrs. Smith and her family.

Maurice F. Lieber, M.D.

Read by Dr. Joseph Sudimack, Jr., Trumbull County, OSMA Secretary-Treasurer.

WHEREAS, Maurice F. Lieber, M.D., born in Canton, Ohio, August 12, 1911, served as President of the Ohio State Medical Association in 1975-76; and

WHEREAS, Dr. Lieber was Councilor of the Sixth District from 1969-1975; and

WHEREAS, Dr. Lieber was President of the Stark County Medical Society; and

WHEREAS, Dr. Lieber's distinguished military career included service in the U.S. Armed Forces from 1941-1946; and

WHEREAS, Dr. Lieber, after this long and distinguished career, died on December 31, 1985; therefore be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association recognizes the contributions Dr. Lieber has made to the profession of medicine, and observes with sadness the death of this vigorous and accomplished colleague; and, be it further

RESOLVED, That a copy of this resolution with an expression of our sympathy be forwarded to Mrs. Doreen Lieber, and that a memorial resolution be introduced by the Ohio Delegation at the Annual Meeting of the American Medical Association House of Delegates.

Carl A. Lincke, M.D.

Read by Dr. Nermin D. Lavapies, Belmont County, Seventh District Councilor.

WHEREAS, Carl A. Lincke, M.D., born in Alliance, Ohio, December 25, 1905, served as President of the Ohio State Medical Association, 1949-1950, and received the Association's Distinguished Service Award in 1979; and

WHEREAS, Dr. Lincke served as Vice President of the American Medical Association in 1968-1969; and

WHEREAS, Dr. Lincke was a Delegate from Ohio to the American Medical Association from 1946-1971; and

WHEREAS, Dr. Lincke was Councilor of the Seventh District from 1942-1949, and served as President of the Carroll County Medical Society, which he helped to organize in 1935; and

WHEREAS, Dr. Lincke was the Chairman of the AMA's Council on Scientific Assembly, 1961-1962, and served on that council from 1949 to 1962; and

WHEREAS, Dr. Lincke, after this

long and distinguished career, died on November 22, 1985; therefore be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association recognizes the contributions Dr. Lincke has made to the profession of medicine, and observes with sadness the death of this vigorous and accomplished colleague; and, be it further

RESOLVED, That a copy of this resolution with an expression of our sympathy be forwarded to Mrs. Marie Lincke.

Dr. Abromowitz then asked permission of the House for immediate action on the four resolutions without referral and the resolutions were adopted by the House.

Introduction of Resolutions

Dr. Abromowitz announced that because the resolutions had been printed and distributed to the members of the House prior to the meeting and the assignment of resolutions to the Resolutions Committee had also been presented to the House in writing, individual introduction of the resolutions would be waived unless there were objections voiced by the House. There were none and the reading of the resolutions was waived. He also announced that Resolution No. 28-86, "CME Update," was withdrawn by the Stark County Medical Society. There were no objections and the resolution was withdrawn.

Committee on Emergency Resolutions Report

Dr. Abromowitz reported that the Committee on Emergency Resolutions met earlier on May 2 to consider five emergency resolutions as follows: E.R. #1, "The Medicare Quality Protection Act of 1986, Federal S. 2331, Senator John Glenn, Co-Sponsor"; E.R. #2, "CME Evaluations"; E.R. #3, "Tobacco Product Sales"; E.R. #4, " 'Smoke Free' Educational Programs"; E.R. #5, "National Health Service Corps."

It was the decision of the committee that all five met the criteria for the emergency resolution category and were approved for submission to the House.

The report was filed by action of the House and the resolutions were referred as follows: E.R. #1 to Committee No. 1; E.R. #2 to Committee No. 3; E.R. #3 to Committee No. 3; E.R. #4 to Committee No. 3; and E.R. #5 to Committee No. 3.

Action Report on 1985 Resolutions

Dr. Abromowitz announced that a report on the "follow-up" work on 1985 Resolutions had been distributed to the Delegates and Alternates prior to the First Session.

House Recessed

The House than recessed until the final session, 1:00 PM, Sunday, May 4.

Minutes of the Final Session

The final session of the House of Delegates was convened at 1:10 PM.

Dr. Abromowitz welcomed the delegates, alternates and guests to the final session of the House of Delegates.

He then introduced Dr. Frank E. Mayfield, Cincinnati, Past President, and Dr. Carl E. Spragg, New Concord, Past Eighth District Councilor.

Report of the Credentials Committee

Dr. Luther W. High, Holmes County, Chairman of the Credentials Committee, reported that out of 238 delegates eligible to vote, 201 were present, credentialed and seated.

Election of President-Elect

Dr. Abromowitz called for nominations for the office of President-Elect. Dr. S. Baird Pfahl, Jr., Sandusky, placed in nomination Dr. D. Ross Irons, Huron County, Councilor of the Eleventh District. The nomination was seconded by Dr. John J. Gaughan, Cleveland. There were no other nominations and Dr. Irons was elected by acclamation. Dr. Irons expressed his thanks to the House and was seated at the head table.

Report of the Nominating Committee

Dr. S. Marcus Wigser, Delegate, Hamilton County, Chairman of the Nominating Committee, presented the report of the Committee on Nominations as follows:

Councilors

First District: As Councilor of the First District, to succeed himself, Dr. Stanley J. Lucas, Cincinnati, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Lucas was declared reelected Councilor of the First District for a term of two years, 1986-1988.

Third District: As Councilor of the Third District, to succeed himself, Dr. Thomas R. Leech, Lima, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Thomas R. Leech was reelected Councilor of the Third District for a term of two years, 1986-1988.

Fifth District: As Councilor of the Fifth District, to succeed himself, Dr. Donavin A. Baumgartner, Jr., Cleveland, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Baumgartner was reelected Councilor of the Fifth District for a term of two years, 1986-1988

Seventh District: As Councilor of the Seventh District, to succeed herself, Dr. Nermin D. Lavapies, Martins Ferry, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Lavapies was reelected Councilor of the Seventh District for a term of two years, 1986-1988.

Ninth District: As Councilor of the Ninth District, to succeed himself, Dr. Thomas P. Price, Jr., Gallipolis, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Price was reelected Councilor of the Ninth District for a

term of two years, 1986-1988.

Eleventh District: As Councilor of the Eleventh District to succeed Dr. D. Ross Irons, Bellevue, the Committee placed in nomination Dr. Charles G. Adams, Vermilion. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Charles G. Adams was declared elected Councilor of the Eleventh District for a term of two years, 1986-1988.

AMA Delegates

Dr. Wigser then presented the nominees for the office of Delegate to the American Medical Association to serve a term beginning January 1, 1987 and ending December 31, 1988 (8 to be elected): Drs. Herman I. Abromowitz, Dayton; Theodore J. Castele, Cleveland; Stewart B. Dunsker, Cincinnati; Roland A. Gandy, Jr., Toledo; Jerry L. Hammon, Dayton; Edward G. Kilroy, Cleveland; Thomas W. Morgan, Gallipolis; H. William Porterfield, Columbus; Robert N. Smith, Toledo; Joseph Sudimack, Jr., Warren; and Robert G. Thomas, Elyria. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Drs. Abromowitz, Castele, Dunsker, Gandy, Hammon, Morgan, Porterfield and Thomas were declared elected.

For Delegate to the American Medical Association to serve a term beginning May 4, 1986 and ending December 31, 1987 (1 to be elected), the following were nominated: Drs. Edward G. Kilroy, Cleveland; Stanley J. Lucas, Cincinnati; Robert N. Smith, Toledo; and Joseph Sudimack, Jr., Warren. Dr. Smith declined the nomination. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Dr. Sudimack was declared elected.

AMA Alternates

For Alternate Delegate to the American Medical Association to fill a term beginning January 1, 1987 and ending December 31, 1988 (8 to be elected), the nominees were: Drs. Edmund C. Casey, Cincinnati; A. Robert Davies, Troy; John A. Devany, Toledo; Richard B. Fratianne, Cleveland; Edward E. Grable, Canton; Owen E. Johnson, Columbus; Edward G. Kilroy, Cleveland; W. Paul Kilway, Jr., Cuyahoga Falls; Henry G. Krueger, Cleveland; William J. Marshall, Dayton; Thomas R. Leech, Lima; Raymond J. McMahon, Jr., Massillon; S. Baird Pfahl, Jr., Sandusky; Lee J. Vesper, Cincinnati; Claire V. Wolfe, Columbus. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Drs. Casey, Davies, Kilroy, Krueger, Marshall, Pfahl, Vesper and Wolfe were declared elected.

For Alternate Delegate to the American Medical Association to serve a term beginning May 4, 1986 and ending December 31, 1987 (1 to be elected), the nominees were: Drs. John A. Devany, Toledo; Richard B. Fratianne, Cleveland; Edward E. Grable, Canton; Owen E. Johnson, Columbus; W. Paul Kilway, Jr., Cuyahoga Falls; Thomas R. Leech, Lima; and Raymond J. McMahon, Jr., Massillon. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Dr. Devany was declared elected.

The above elections created one unexpired term beginning May 4, 1986 and ending December 31, 1986. A motion was made and seconded not to fill this unexpired term and the motion carried.

Report of Resolutions Committee No. 1

Dr. Theodore J. Castele, Cuyahoga County, as chairman, presented the report of Resolutions Committee No. 1:

Reference Committee 1 gave careful consideration to the several items referred to it.

RESOLUTION NO. 01-86
AMA Alternate Delegate to be Elected by OSMA Medical Student Section

The Committee recommends **adoption of Resolution No. 01-86.**

RESOLVED, That one alternate delegate to the AMA be designated as a medical student alternate delegate to be elected by the OSMA Medical Student Section Assembly in accordance with the constitution and bylaws of the OSMA and the bylaws of the Medical Student Section; and, be it further

RESOLVED, That the OSMA bylaws be amended as follows to allow for such election:

Chapter 4. Section 7. Delegates to the American Medical Association. The House of Delegates shall elect representatives to the House of Delegates of the American Medical Association in accordance with the constitution and bylaws of that body, except for one alternate delegate, who shall be elected by the Medical Student Section in accordance with the constitution and bylaws of this Association and the bylaws of the Medical Student Section.

Chapter 5. Section 5. Nomination of Officers and Delegates and Alternate Delegates to the American Medical Association. The report of the Committee on Nominations with respect to all offices, except that of President-Elect, and with respect to all Delegates and Alternate Delegates to the American Medical Association, except for the alternate delegate elected by the Medical Student Section, shall be posted at the registration desk of the Association at the earliest time practicable and at least three hours before the final session of the House of Delegates. Nominations for the office of President-Elect shall be made from the floor at the final session of the House of Delegates. Each nominating speech for any office shall be limited to three minutes. Not more than one speech shall be made in seconding a given nomination and such seconding speech shall be limited to one minute.

Chapter 5. Section 7. Election of Officers and of Delegates and Alternate Delegates to the American Medical Association. The election of officers of this Association and of delegates and alternate delegates to the American Medical Association shall be by ballot. The election of delegates to the American Medical Association

shall be conducted by means of a single ballot sheet and the election of alternate delegates shall likewise be conducted by means of a separate single ballot sheet. Election of one alternate delegate to the American Medical Association by the OSMA Medical Student Section shall be in accordance with the bylaws of the Medical Student Section.

In the event there is only one position to be filled, the nominee receiving the majority of all votes cast shall be declared elected. In case no nominee receives a majority on the first ballot, the two nominees receiving the lowest number of votes shall be dropped and a new ballot taken; this procedure shall be continued until there are two nominees remaining. The nominee receiving a majority of all votes cast shall be declared elected.

In the event there is more than one position to be filled from among any number of nominees, a nominee, in order to be declared elected, must receive the votes of a majority of those voting, provided, however, that if upon any ballot the number of nominees receiving a majority vote is greater than the number of positions to be filled on such ballot, those nominees (not to exceed the number of positions to be filled on such ballot) receiving the greatest number of votes shall be declared elected. If upon any ballot some but not all of such positions are filled, a new ballot shall be taken from among all of the remaining nominees; except that the two nominees receiving the lowest number of votes on the previous ballot shall be dropped on each new ballot until there are two more nominees than positions available, after which the nominee receiving the lowest number of votes shall be dropped. On every ballot a nominee, in order to be declared elected, must receive the votes of a majority of those voting, provided, however, that if upon such new ballot the number of nominees receiving a majority vote is greater than the number of positions to be filled on such ballot, those nominees (not to exceed the number of positions to be filled on such ballot) receiving the greatest number of votes cast shall be declared elected. If upon any ballot no nominee receives the votes of a majority of those voting, the two nominees receiving the lower number of votes shall be dropped and a new ballot will be taken; this procedure shall be continued until there are two more nominees than positions available, after which the nominee receiving the lowest number of votes shall be dropped; and this procedure shall be continued until all positions have been filled.

Chapter 8. Section 5. Terms of Office for Medical Student Section Alternate Delegate. The alternate delegate elected by the Medical Student Section shall serve for a period of one year from the time of election. This alternate delegate shall be eligible for reelection so long as medical student status is maintained.

By official action, **the House voted to adopt Resolution No. 01-86.** Joel Gelman, the Medical Student Section representative from Medical College of Ohio, Toledo, was elected to fill this position for 1986-87.

RESOLUTION NO. 02-86
Relationship of OSMA to Medical Insurance Carriers

The Committee recommends **rejection of Resolution No. 02-86.**

By official action, **the House voted to reject Resolution No. 02-86.**

RESOLUTION NO. 03-86
OSMA Balance Sheet, December 31, 1984 and 1983

The Committee recommends **filing Resolution No. 03-86.**

Without objection, Resolution No. 03-86 was filed.

RESOLUTION NO. 04-86
Standardization of Mandatory Second Surgical Opinion Programs

The Committee recommends **adoption of Substitute Resolution No. 04-86 and I so move.**

RESOLVED, That the Ohio State Medical Association urge that third party payors, requiring second surgical opinions, educate their subscribers so that they understand ~~and agree to~~ the second surgical opinion requirements of such programs; and, be it further

RESOLVED, That the Ohio State Medical Association encourage the American Medical Association to seek standardization of administrative procedures for all mandatory second surgical opinion programs.

By official action, the House **voted to make a minor amendment in the Substitute Resolution, the deletion of three words as shown by strike-outs, and to adopt it as amended.**

RESOLUTION NO. 05-86
Mandatory Second Opinion

The Committee recommends **adoption of Amended Resolution No. 05-86.**

RESOLVED, That the Ohio State Medical Association consider it inappropriate and unethical for the physician rendering a required second opinion to assume continuing care of the patient.

By official action, **the House referred Resolution No. 05-86 to the OSMA Council.**

RESOLUTION NO. 06-86
Standardization of Preadmission Certification Criteria

The Committee recommends **adoption of Amended Resolution No. 06-86.**

RESOLVED, That the Ohio State Medical Association urge the American Medical Association to seek standardization of administrative procedures for preadmission certification programs, including both the administrative requirements to be met and the forms to be completed.

By official action, **the House adopted Amended Resolution No. 06-86.**

RESOLUTION NO. 07-86
Medicare Freeze

The Committee recommends **referral of Resolution No. 07-86 to Council.**

RESOLVED, The Ohio State Medical Association and the American Medical Association should inform the public that payments for care of Medicare patients are restricted and that quality and availability of care are threatened.

By official action, **the House referred Resolution No. 07-86 to the OSMA Council.**

SUBSTITUTE RESOLUTION NO. 08-86
(Replacing No. 08-86)
Physician Reimbursement for Home Health Care

The Committee recommends **adoption of Substitute Resolution No. 08-86 and I so move.**

RESOLVED, That the Ohio State Medical Association petition government and other third party carriers to allow for equitable remuneration consistent with services rendered ~~for~~ BY physicians ~~time~~ involved in treating patients at home; and, be it further

RESOLVED, That the Ohio State Medical Association present a similar resolution to the American Medical Association at the next meeting.

By official action, **the House voted to amend Substitute Resolution No. 08-86, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

SUBSTITUTE RESOLUTION NO. 11-86
Support of Free Choice of Personal Physicians by Participants in Government Programs

The Committee recommends **adoption of Substitute Resolution No. 11-86 and I so move.**

RESOLVED, The Ohio State Medical Association only support legislation that protects the right of freedom of choice of physician for participants in government sponsored health care programs.

By official action, **the House voted to adopt Substitute Resolution No. 11-86.**

AMENDED RESOLUTION NO. 12-86
OSMA Quality of Care Clearinghouse

The Committee recommends **referral of Amended Resolution No. 12-86 to Council.**

RESOLVED, That the Ohio State Medical Association through its staffing and committee system develop a reporting mechanism to evaluate the reduction in quality of health care delivered.

By official action, **the House referred Amended Resolution No. 12-86 to the OSMA Council.**

RESOLUTION NO. 13-86
Restriction on Timing of Admissions

The Committee recommends **rejection of Resolution No. 13-86.**

RESOLVED, That the Ohio State Medical Association support the concept that the attending ~~surgeon is~~ PHYSICIAN OR PHYSICIANS best qualified to determine the timing of a patient's admission and that arbitrary lists of "admission day" procedures may lead to less than optimal patient care.

By official action, **the House voted to amend Resolution No. 13-86, as indicated in capital letters with deletions as noted, and referred Amended Resolution No. 13-86 to the OSMA Council.**

RESOLUTION NO. 14-86
Gramm-Rudman: Medical Voucher

The Committee recommends **referral of Resolution No. 14-86 to Council.**

RESOLVED, That members of the House of Delegates of the Ohio State Medical Association suggest to the Ohio Department of Human Services to establish a medical voucher system for the Medicaid program, which:

1) Would allow the State to set a monetary value on each medical care coupon in keeping with what might be permitted by the state financial reserves for the program.
2) Would permit the State to even make a nominal charge of 25 to 50 cents per voucher issued to qualifying Ohio citizens; this would restore citizen self-respect and self-esteem.
3) Would permit the State to issue the vouchers free in those cases where there was total lack of financial resources on the part of those who qualified.
4) Would make it possible for those rendering medical and health care services to receive the vouchers as partial payment and deposit same as financial notes honored by the local banking institutions — according to the assigned state treasury value.
5) Would permit the doctor-patients-health care institutions to make individual arrangements, if any, for the proper settlement of whatever balance of payments would remain for the services rendered; and, be it further

RESOLVED, That the Ohio State Medical Association House of Delegates refer this resolution to the House of Delegates of the American Medical Association for the possibilities that the American Medical Association work with the Department of Health and Human Services and Congress to develop a similar national program.

By official action, **the House referred Resolution No. 14-86 to the OSMA Council.**

EMERGENCY RESOLUTION NO. 01-86
(Resolution No. 46-86)
The Medicare Quality Protection Act of 1986 S. 2331 — Senator John Glenn, Co-Sponsor

The Committee recommends **referral of Emergency Resolution No. 01-86 to Council.**

RESOLVED, That the Ohio State Medical Association support the efforts of S. 2331, the Medicare Quality Protection Act of 1986, co-sponsored by Senator John Glenn, 1) to require the Secretary of Health and Human Services to improve the DRG payment system to cover the cost of hospitalization for severe, prolonged illness, 2) to protect patients from premature hospital discharge without adequate discharge planning, 3) to prohibit hospitals from offering "kickbacks" to physicians for discharging patients prematurely, 4) to penalize physicians who accept such "kickbacks," 5) to improve Medicare payment for necessary post-hospital care, and 6) to mandate PROs to evaluate quality of care rather than focusing solely on cost; and, be it further

RESOLVED, That the Ohio State Medical Association ask the American Medical Association to support these proposals; and, be it further

RESOLVED, That the Ohio State Medical Association notify all Ohio Congressmen of the Ohio State Medical Association's support for these proposals.

By official action, **the House**

referred Emergency Resolution No. 01-86 to the OSMA Council.

RESOLUTION NO. 09-86
Quality Assurance

The Committee has placed this resolution on the **Consent Calendar and recommended its adoption.**

RESOLVED, That the Ohio State Medical Association encourage local medical societies and their members to be involved with quality assurance mechanisms for alternative delivery systems and all other health care payment and delivery systems operating in their county; and, be it further

RESOLVED, That the members of those quality assurance mechanisms assure that patient care is consistent with accepted standards of medical practice.

By consent, **the House adopted Resolution No. 09-86.**

RESOLUTION NO. 10-86
HCFA and PRO

The Committee has placed this resolution on the **Consent Calendar and recommended its rejection.**

By consent, **the House voted to reject Resolution No. 10-86.**

THE REPORT OF RESOLUTIONS COMMITTEE NO. 1, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

Dr. Abromowitz yielded the chair to Dr. Albers who called for the report of Resolutions Committee No. 2.

Report of Resolutions Committee No. 2

Dr. Roland A. Gandy, Jr., Lucas County, as chairman, presented the report of Resolutions Committee No. 2:

Reference Committee 2 gave careful consideration to the several items referred to it.

RESOLUTION NO. 15-86
Mandated Medical Professional Liability Insurance

The Committee recommends **adoption of Resolution No. 15-86.**

RESOLVED, That the Ohio State Medical Association work with the Ohio Hospital Association to address the issue of hospital liability insurance carriers requiring mandated minimum limits of professional liability insurance for members of a hospital medical staff; and, be it further

RESOLVED, That the Ohio State Medical Association, in cooperation with the Ohio Hospital Association, develop guidelines specifying the respective rights of a hospital board of trustees and hospital medical staff regarding medical professional liabilty insurance; and, be it further

RESOLVED, That the Ohio State Medical Association voice its opposition to the practice of insurance companies and hospital boards of trustees unilaterally requiring all physicians, regardless of their specialty or type of practice to carry a specific amount of professional liability insurance as a condition for continued membership on a hospital medical staff; and, be it further

RESOLVED, That the Ohio State Medical Association oppose any action by an insurance carrier or hospital board of trustees to require any amendment to the bylaws of a hospital medical staff as a condition for insurance; and, be it further

RESOLVED, That this resolution, with appropriate editorial modification, be submitted to the American Medical Association.

By official action, **the House voted to adopt Resolution No. 15-86.**

RESOLUTION NO. 16-86
Computer Network to Identify Persons Who Have Filed Malpractice Suits

The Committee recommends **rejection of Resolution No. 16-86.**

By official action, **the House voted to reject Resolution No. 16-86.**

SUBSTITUTE RESOLUTION No. 17-86
Professional Liability
(Replacing 17-86, 23-86 and 24-86)

The Committee recommends **adoption of Substitute Resolution No. 17-86 and I so move.**

RESOLVED, That the OSMA Task Force on Professional Liability and the OSMA Council be commended for their preparations for addressing this important issue; and, be it further

RESOLVED, That the OSMA Task Force on Professional Liability and the OSMA Council continue educational efforts, formation of coalitions; preparation for a solicitation of OSMA members to finance remedial efforts; and establishment and encouragement of other remedial activities, such as risk management programs and loss prevention initiatives; and, be it further

RESOLVED, That at the appropriate time a legislative tort reform program be introduced to the Ohio General Assembly, including but not limited to, the following reforms:

1. Limit non-economic damages, such as pain and suffering, mental anguish, and punitive damages to a fair and reasonable maximum dollar amount;
2. Mandate structured settlements based on a periodic payment and itemization of awards system;
3. Reduce awards in cases where a plaintiff can be compensated by collateral sources to prevent windfall or extraordinary recovery;
4. Limit attorneys' contingency fees utilizing a sliding scale;
5. If necessary, re-define the statute of limitations to prevent the possibility of open-ended liability, dependent upon pending court decisions;
6. Create disincentives in the law for plaintiffs and their representatives who wish to file frivolous suits.

By official action, **the House referred Substitute Resolution No. 17-86 to the OSMA Council.**

SUBSTITUTE RESOLUTION NO. 18-86
(Replacing 18-86 and 19-86)
Ceiling Priced, Pool-Risk Insurance Legislation

The Committee recommends **adoption of Substitute Resolution No. 18-86, and I so move.**

RESOLVED, That the Ohio State Medical Association investigate the problem of non-availability of affordable health insurance for patients who are considered by the insurance industry to be a high risk (such as diabetes, debilitating arthritis, sickle cell anemia, etc.) and recommend legislative solutions such as Ceiling Priced, Pool-Risk Insurance;

and, be it further

RESOLVED, That the results of this investigation be referred to the OSMA Council for appropriate action; and, be it further

RESOLVED, That a report be presented at the 1987 Annual Meeting of the Ohio State Medical Association House of Delegates.

By official action, **the House voted to adopt Substitute Resolution No. 18-86.**

SUBSTITUTE RESOLUTION NO. 20-86
(Replacing No. 20-86 and 21-86)
Criteria for Categorizing Hospitals for the Management of Trauma

The Committee recommends **adoption of Substitute Resolution No. 20-86 and I so move.**

RESOLVED, That the Ohio State Medical Association in cooperation with other health care groups work with the Director of the Ohio Department of Health and the Ohio General Assembly to develop legislation establishing a non-profit entity charged with categorizing hospitals for the management of trauma using a modification of criteria of the American College of Surgeons; and, be it further

RESOLVED, That this legislation require periodic ~~recertification~~ REVERIFICATION based on level of performance and compliance with established standards.

By official action, **the House voted to amend Substitute Resolution No. 20-86 as indicated in capital letters with deletion as noted, and referred as amended to the OSMA Council with a report back.**

SUBSTITUTE RESOLUTION NO. 22-86
(Replacing No. 22-86)
Pediatric Emergency Care

The Committee recommends **adoption of Substitute Resolution No. 22-86 and I so move.**

RESOLVED, That the Ohio State Medical Association support efforts to provide training in pediatric advanced life support and trauma for all emergency care providers, especially those involved in prehospital care.

By official action, **the House adopted Substitute Resolution No. 22-86.**

AMENDED RESOLUTION NO. 25-86
Living Wills

The Committee recommends **adoption of Amended Resolution No. 25-86.**

RESOLVED, That the Ohio State Medical Association encourage individual members to acknowledge, when appropriate, a living will in determining the care of terminally ill patients.

By official action, **the House adopted Amended Resolution No. 25-86.**

RESOLUTION NO. 26-86
Public Health Discrimination

The Committee recommends **referral of Resolution No. 26-86 to Council.**

RESOLVED, That the Ohio State Medical Association instruct its Legislative Committee to draft and seek a sponsor to introduce in the State of Ohio legislation that would make it illegal to discriminate in any fashion against any individual with a positive HTLV-III/BLOT Test.

By official action, **the House referred Resolution No. 26-86 to the OSMA Council.**

RESOLUTION NO. 27-86
Development and Adoption of a Formal Policy by the OSMA Concerning the Medical Student, Resident or Staff Health Care Professional Infected by or Carrying HTLV-III (AIDS and AIDS Related Complex Virus)

The Committee recommends **referral of Resolution No. 27-86 to Council.**

RESOLVED, That Ohio State Medical Association shall support and actively participate in the formation and adoption of a formal policy stating its position concerning infection of a medical student, resident or staff health care professional with HTLV-III, creating guidelines which justly confront the unique difficulties and conditions which such an infection produces for the afflicted individual and those he or she comes in contact with through their position in the medical college, university or teaching hospital.

By official action, **the House referred Resolution No. 27-86 to the OSMA Council.**

REPORT A — 1986
OSMA Ad Hoc Committee to Review OSMA House of Delegates Policy

The Committee has placed this report on the Consent Calendar and recommended adoption. The report reads as follows:

POLICIES TO BE RETAINED — 1982 HOUSE OF DELEGATES PROCEEDINGS

9-82	Parliamentarian
10-82	Establishment of a Resident Physician's Section Within the OSMA
13-82	Mandatory CME
Report B	OSMA Interim Sessions and Update Meetings
20-82	Participation Agreements Offered by Blue Shield Plans in Ohio
21-82	Assignment of Insurance Benefits
23-82	Health Planning Advisory Panel
24-82	Medical Staff Representation on the Board of Trustees of a Tax Supported Hospital
25-82	The American Student in Foreign Medical Schools
27-82	To Develop Within the MSS Programs Which Would Assist in Improving the Public Health
28-82	To Establish and Announce MSS Involvement in Community Public Health Affairs Projects
29-82	To Establish and Announce a Program Which Would Supply Medical Students as Speakers at Civic and Career-Orientation Programs
30-82	To Establish a Program Which Would Match Medical Students with Externship and Elective Rotations Available in Ohio
31-82	Strengthening of Ohio's Drunk Driving Laws
35-82	Education Regarding Suicide Recognition, Prevention and Treatment

By consent, **the House adopted Report A — 1986.**

THE REPORT OF RESOLUTIONS COMMITTEE NO. 2, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

Dr. Albers yielded the chair to Dr. Abromowitz who called up the report of Resolutions Committee No. 3.

Report of Resolutions Committee No. 3

Dr. Walter A. Reiling, Jr., Montgomery County, as chairman, presented the report of Resolutions Committee No. 3:

Reference Committee 3 gave careful consideration to the several items referred to it.

RESOLUTION NO. 28-86
CME Update
(WITHDRAWN)

RESOLUTION NO. 29-86
State Medical Board Actions

The Committee recommends **rejection of Resolution No. 29-86.**

By official action, **the House rejected Resolution No. 29-86.**

RESOLUTION NO. 30-86
State Medical Board of Ohio

The Committee recommends **rejection of Resolution No. 30-86.**

By official action, **the House rejected Resolution No. 30-86.**

RESOLUTION NO. 31-86
Health Care Technicians

The Committee recommends **referral of Resolution No. 31-86 to Council.**

RESOLVED, That the Ohio State Medical Association bring to the attention of the State Medical Board the confusion in the identity and function of Physician's Assistants and other categories of Physician Extenders which is arising in the minds of patients and the public at large; and, be it further

RESOLVED, That the Ohio State Medical Association urge the State Medical Board to develop guidelines regarding the nomenclature and means of identification of Physician's Assistants and other categories of Physician Extenders, such guidelines to embody a change in the name from Physician's Assistants to Health Care Technicians.

By official action, **the House referred Resolution No. 31-86 to the OSMA Council.**

AMENDED RESOLUTION NO. 32-86
Foreign Medical Graduates

The Committee recommends **adoption of Amended Resolution No. 32-86.**

RESOLVED, That the Ohio State Medical Association continue to work to protect the rights and privileges of all physicians duly licensed in the State of Ohio regardless of ethnic or educational background; and be it further

RESOLVED, That the Ohio State Medical Association oppose any legislative efforts to discriminate among duly Ohio-licensed physicians on the basis of ethnic or educational background; and, be it further

RESOLVED, That the Ohio State Medical Association introduce a similar resolution to the American Medical Association.

By official action, **the House adopted Amended Resolution No. 32-86.**

AMENDED RESOLUTION NO. 33-86
The Patient and Program Protection Act for Medicare and Medicaid, S. 837 (Senator John Glenn, Co-Sponsor)

The Committee recommends **adoption of Amended Resolution No. 33-86.**

RESOLVED, That the Ohio State Medical Association support the basic concept of a national computer tracking system so that state licensing boards will know when and why (where permitted by state law) physicians' licenses have been revoked, suspended or reinstated in other states.

By official action, **the House adopted Amended Resolution No. 33-86.**

AMENDED RESOLUTION NO. 34-86
House Bill No. 769

The Committee recommends **adoption of Amended Resolution No. 34-86.**

RESOLVED, That the House of Delegates commend the Legislative Committee, Legislative Department, and the Department of Legal Services for excellent work on House Bill 769, a bill to strengthen the disciplinary powers of the Ohio State Medical Board.

By official action, **the House adopted Amended Resolution No. 34-86.**

SUBSTITUTE RESOLUTION NO. 35-86
(Replacing 35-86, 36-86, 37-86, 38-86, 39-86, 40-86, E.R. 03-86, E.R. 04-86)
OSMA Support of a Tobacco-Free Society

The Committee recommends **adoption of Substitute Resolution No. 35-86 and I so move.**

RESOLVED, That the Ohio State Medical Association support a tobacco-free society by the year 2000 through enactment of the following policies:

1. That smoking be prohibited at all meetings sponsored by the OSMA, and that proactive non-smoking policies be developed for the OSMA membership and staff.

2. That OSMA support state legislation to control smoking in public places, to permit local governments to adopt local smoking regulations, to prohibit vending machine sales of cigarettes and tobacco products, and to set the minimum legal age for purchasing tobacco products at 21.

3. That OSMA lend its support to the already announced position of the American Medical Association for federal legislation to raise the federal excise tax on cigarettes with revenues from the increase being apportioned to Medicare.

4. That OSMA support legislation to prohibit the sale of tobacco products in health care institutions.

5. That the Ohio delegation submit a resolution to the American Medical Association House of Delegates 1986 Annual Meeting calling for legislation to ban smoking on all commercial airline flights within the continental United States.

6. That OSMA continue to support

strong educational efforts, from kindergarten through the 12th grade, to help pre-teens, adolescents, and young adults avoid the use of tobacco products, including smokeless tobacco; and be it further

RESOLVED, That the Ohio State Medical Association commend the cities of Xenia and Cincinnati for their successful efforts in enacting ordinances to ban smoking in public places.

By official acction, **the House adopted Substitute Resolution No. 35-86.**

SUBSTITUTE RESOLUTION NO. 41-86
(Replacing 41-86 and 42-86)
Ban on Amphetamine and Methamphetamine in the State of Ohio

The Committee recommends **adoption of Substitute Resolution No. 41-86.**

RESOLVED, That the Ohio State Medical Association continue to work with the Ohio State Medical Board in developing regulations for the safe and appropriate use of amphetamines and methamphetamines: and, be it further,

RESOLVED, That the Ohio State Medical Association support the recommendations of the Ohio PADS project and that the House of Delegates commend the Council of the Ohio State Medical Association for this initiative.

By official action, **the House voted to adopt Substitute Resolution No. 41-86.**

AMENDED RESOLUTION NO. 43-86
Funding for Full-time Medical Director, Physician Effectiveness Program

The Committee recommends **adoption of Amended Resolution No. 43-86.**

RESOLVED, That the Ohio State Medical Association and its 11,000 dues paying members urge all liability insurance carriers providing either hospital liability insurance to Ohio licensed hospitals, or medical professional liability insurance to Ohio licensed physicians, to assist in the funding of the full-time medical director and staff for the Physician Effectiveness Program; and, be it further

RESOLVED, That if sufficient funding for the full-time medical director and staff has not been obtained by December 31, 1986, that the OSMA membership be assessed annually, for three years, a per capita amount which would ~~raise the difference between funds already raised and the three year total of $750,000.~~ MATCH DOLLAR FOR DOLLAR UP TO A MAXIMUM THREE YEAR TOTAL OF $375,000.00. THE TOTAL THUS RAISED FROM INSURANCE CARRIERS AND OSMA MEMBERSHIP WOULD BE $750,000.00.

By official action, **the House voted to amend Amended Resolution No. 43-86, as indicated in capital letters with deletions as noted, and referred it to the OSMA Council.**

SUBSTITUTE EMERGENCY RESOLUTION NO. 02-86
(Replacing E.R. 02-86)
CME Program Evaluations

The Committee recommends **adoption of Substitute Emergency Resolution No. 02-86 and I so move.**

RESOLVED, That OSMA Council instruct the Committee on Education to seek to simplify and streamline the CME Program accreditation standards, within the scope of the ACCME guidelines.

By official action, **the House adopted Substitute Emergency Resolution No. 02-86.**

SUBSTITUTE EMERGENCY RESOLUTION NO. 05-86
National Health Service Corps

The Committee recommends **adoption of Substitute Emergency Resolution No. 05-86 and I so move.**

~~RESOLVED, That the Ohio State Medical Association work aggressively for the cancellation of the Private Practice Option portion of the National Health Service Corps Program, and that those physicians with Federal obligations return to the care of the medically needy, indigent, etc.; and, be it further~~

RESOLVED, That the Ohio State Medical Association request immediate review by the ~~U.S. Public Health Service~~ NATIONAL HEALTH SERVICE CORPS of the current designation of Sandusky County as a Health Manpower Shortage Area, that this review be studied by the OSMA Council, and that legal action be considered if appropriate; and, be it further

~~RESOLVED, That the Ohio Delegation to the American Medical Association submit a resolution to the House of Delegates requesting elimination of the National Health Service Corps, Private Practice Option; and, be it further~~

RESOLVED, THAT THE OSMA WORK AGGRESSIVELY FOR PROPER APPLICATION OF PLACEMENT PROCEDURES FOR THE PRIVATE PRACTICE OPTION PORTION OF THE NATIONAL HEALTH SERVICE CORPS PROGRAM, INCLUDING REQUIRED PREPLACEMENT PARTICIPATION BY STATE AND LOCAL MEDICAL SOCIETIES; AND, BE IT FURTHER

RESOLVED, THAT THE OHIO DELEGATION TO THE AMA SUBMIT A RESOLUTION TO THE HOUSE OF DELEGATES REQUESTING THE AMA BOARD OF TRUSTEES AND LEGAL DEPARTMENT TO NEGOTIATE WITH THE NATIONAL HEALTH SERVICE CORPS TO CORRECT SERIOUS PROBLEMS WITH THE NATIONAL HEALTH SERVICE CORPS PROGRAM; AND, BE IT FURTHER

RESOLVED, THAT THE OSMA THROUGH ITS MEDICAL STUDENT SECTION, INFORM ALL STUDENTS OF ALL ELEMENTS OF THEIR CONTRACT WITH NHSC INCLUDING ALL PENALTIES AND THAT THE AMA BE ENCOURAGED TO DO LIKEWISE ON THE NATIONAL LEVEL.

By official action, **the House voted to amend Substitute Emergency Resolution No. 05-86, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

PRESIDENT'S ADDRESS

President Abromowitz opened his address by emphasizing that OSMA must face the future with dedication to

the commitment of being a caring profession with quality as the guiding beacon.

In reviewing his term as President, he cited the accomplishments of several committees and departments. The Committee on Legislation chaired by William Marshall, M.D. was commended for its work with House Bill 315 to revise the Nurse Practice Act. Although nursing has withdrawn its support for the bill following a large number of OSMA amendments, Dr. Abromowitz explained that OSMA supports the concept of an updated Nurse Practice Act, and looks forward to meeting with the leadership of Ohio's nurses to bring about appropriate solutions to practice issues.

Other highlights included:

- A bill (House Bill 769) with major OSMA input to expand the powers of the Ohio State Medical Board.
- OSMA's leadership role in the Prescription Abuse Data Synthesis program sponsored by the American Medical Association. PADS is designed to identify and eliminate sources of illegal drug diversion.
- The work of the all-important Task Force on Professional Liability and its four subcommittees to head off a potential statewide crisis. OSMA will soon have a legislative package for consideration by the Ohio General Assembly.

Dr. Abromowitz stressed that education of patients, legislators and the general public is the key to success in our efforts to avert a major professional liability crisis in Ohio. In this regard, he announced the development of a special communications kit on professional liability to be distributed initially to House of Delegates members.

The President urged all physicians to join OMPAC in order to voice opinions and concerns as physicians to our elected representatives.

A positive report on the OSMA Public Education Campaign, initiated at the beginning of his term in May, 1985, was presented by Dr. Abromowitz. He commended the efforts of county medical societies in sponsoring health fairs, newspaper supplements, and "mini-internships" in medicine for community leaders.

Continued on page 557

Ohio State Medical Journal Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted *in the original* on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). *The entire text including lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.*

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. *The Journal* will assume $10 of this expense and the author will be billed by *The Journal* for the remainder.

(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

(c). Legends for the figures should be written on separate paper.

(d). The author must affirm that he has *written releases* on all photographs in which patients can be identified.

5. **ABSTRACTS.** A *short* (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the *order of their appearance in the text.*

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2. Doe J, Roe RX: How to go about it. Ohio State MJ 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: Modern Medicine, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should *not* be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections and to have the manuscript retyped. Any changes, other than typographical errors, made by the Author after the manuscript is set in type will be billed to him at $2 per line.

11. **REPRINTS.** An order blank for reprints with a table covering cost will be sent with the galley proofs to the Senior Author. *The Journal* does not profit on reprint orders.

12. **EDITORIAL ASSISTANCE.** Ms. Deborah Athy, Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

OSMA Councilors

Listed below are the OSMA Councilors and the districts they represent. If you have any questions or concerns regarding OSMA, please address them to your Councilor.

First District
Stanley J. Lucas, M.D.
2905 Burnet Avenue
Cincinnati, Ohio 45202
Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren

Second District
William J. Marshall, M.D.
2600 Far Hills Avenue
Dayton, Ohio 45419
Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, and Shelby

Third District
Thomas R. Leech, M.D.
718 W. Market St., Suite 050
Lima, Ohio 45801
Allen, Auglaize, Crawford, Hancock, Hardin, Logan, Marion, Mercer, Seneca, Van Wert, and Wyandot

Fourth District
John A. Devany, M.D.
2743 W. Central Avenue
Toledo, Ohio 43606
Defiance, Fulton, Henry, Lucas, Ottawa, Paulding, Putnam, Sandusky, Williams, and Wood

Fifth District
Donavin A. Baumgartner, Jr., M.D.
11311 Shaker Boulevard
Cleveland, Ohio 44104
Ashtabula, Cuyahoga, Geauga, and Lake

Sixth District
J. James Anderson, M.D.
5204 Mahoning Ave., Suite 103
Youngstown, Ohio 44515
Columbiana, Mahoning, Stark, and Trumbull

Seventh District
Nermin D. Lavapies, M.D.
1220 Hughes Avenue
Martins Ferry, Ohio 43935
Belmont, Carroll, Coshocton, Harrison, Jefferson, Monroe and Tuscarawas

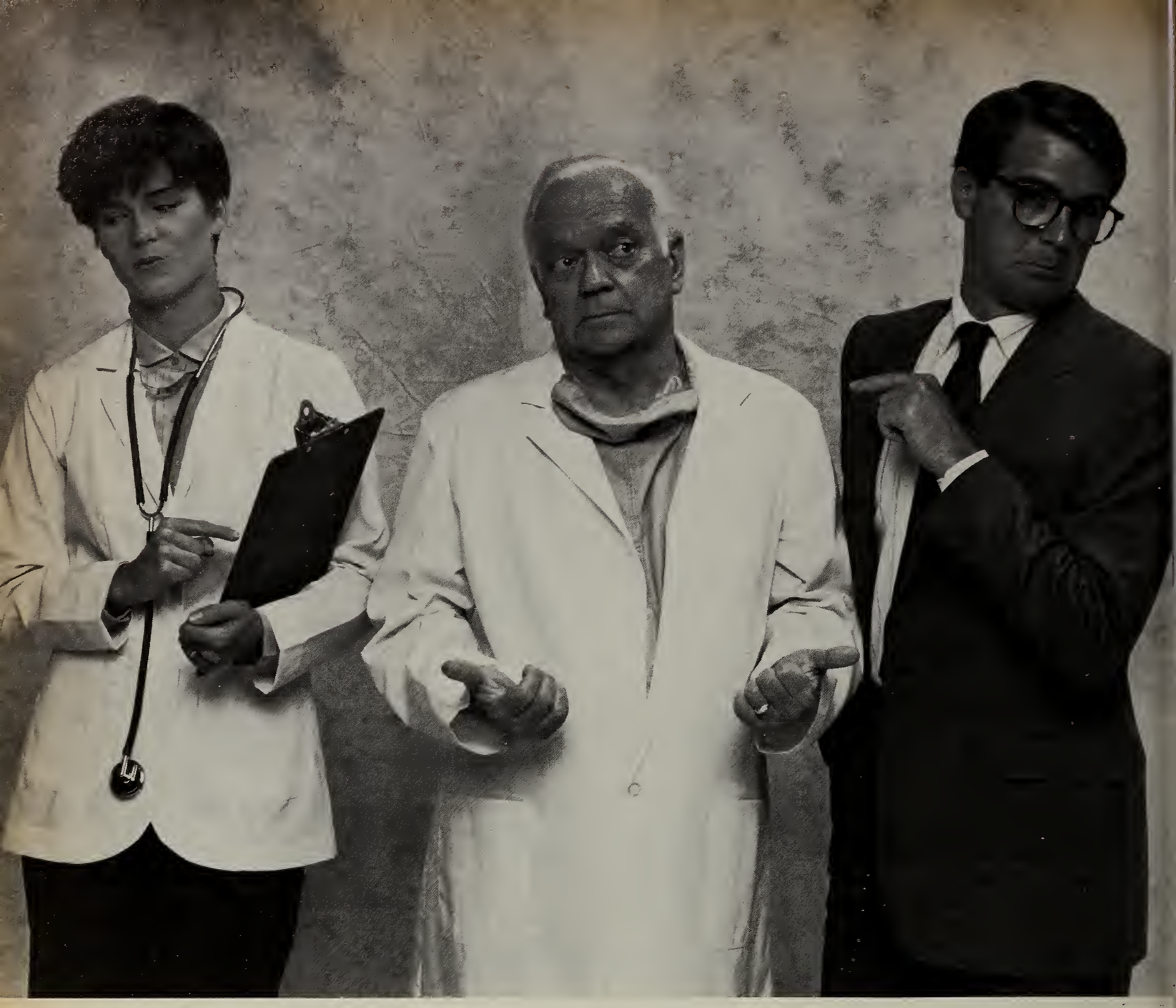
Eighth District
John F. Kroner, Jr., M.D.
Box 708
Athens, Ohio 45701
Athens, Fairfield, Guernsey, Licking, Morgan, Muskingum, Noble, Perry, and Washington

Ninth District
Thomas P. Price, Jr., M.D.
Holzer Medical Clinic
385 Jackson Pike
Gallipolis, Ohio 45631
Gallia, Hocking, Jackson, Lawrence, Meigs, Pike, Scioto, and Vinton

Tenth District
H. William Porterfield, M.D.
1100 Morse Road
Columbus, Ohio 43229
Delaware, Fayette, Franklin, Knox, Madison, Morrow, Pickaway, Ross, and Union

Eleventh District
Charles Adams, M.D.
13906 W. Lake Road
Vermilion, Ohio 44089
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VENTRICULAR ARRHYTHMIAS FOLLOWING INTRAVENOUS CANCER CHEMOTHERAPY

Arrhythmias and Chemotherapy

Donald V. Unverferth, MD
Stanley P. Balcerzak, MD
Carl V. Leier, MD
James A. Neidhart, MD

This study was designed to determine if cancer chemotherapeutic agents induce ventricular arrhythmias and what risk factors predispose patients to arrhythmias. Electrocardiographic monitoring of 33 patients demonstrated that ventricular ectopy occurred most commonly in the first two hours after chemotherapy and that ectopy was more common after than before therapy. However, ectopy occurred as frequently after placebo as after chemotherapy. Risk factors for arrhythmias include an abnormal left ventricular function and a prolonged QT interval. Thus, chemotherapy patients should be well-informed before the administration of drug therapy, and patients with abnormal ventricular function or a prolonged QT interval should be closely monitored.

The frequency, severity and cause of arrhythmias following cancer chemotherapy are not known. This study was designed to determine if Phase I cancer chemotherapeutic agents induce ventricular arrhythmias, to determine the time course of ventricular ectopy, and to determine what risk factors may predispose patients to the development of arrhythmias. In the first part of the study, 24-hour electrocardiographic monitor recordings of 33 patients demonstrated that the greatest amount of ectopy occurred in the first two hours after administration of the chemotherapeutic agent and that these arrhythmias were more frequent for the two hours after than prior to therapy. In the second part of this study, the order of administration of placebo or a chemotherapeutic agent was randomly assigned and both patients and medical personnel were blinded. Electrocardiographic monitors revealed that no significant difference was recorded in the number of premature ventricular contractions per hour for the two hours after drug when compared to placebo. Finally, the charts of 55 patients who had 24-hour electrocardiographic monitoring after chemotherapy were reviewed to determine what predisposed each to ventricular arrhythmias. Significant factors were an abnormal left ventricular function and a prolonged QT interval (corrected for heart rate) or a QT interval that became prolonged after chemotherapy. The heart rate and the type of chemotherapeutic agent were not significant factors. Thus, patients should be well-informed before the administration of Phase I chemotherapeutic agents and reassessed during therapy. In addition, those patients with abnormal ventricular function and/or a prolonged QT interval should be closely monitored.

From the Department of Medicine, Divisions of Cardiology and Hematology and Oncology, The Ohio State University College of Medicine, Columbus, Ohio.
This study supported in part by the Central Ohio Heart Chapter of the American Heart Association.

INTRODUCTION

Administration of anthracyclines causes acute ion shifts in the myocardial cell[1] as well as alterations in membranes[2] and nuclear structures.[3] The most commonly noted clinical changes in the first several hours after doxorubicin injection are reversible non-specific electrocardiographic abnormalities — usually ST and T wave changes.[4] Although these are rarely of any clini-

cal significance, Wortman et al[5] described three patients who died suddenly after administration of doxorubicin.

Arrhythmias have also been observed following the administration of non-anthracycline agents as well. The severity and frequency of these arrhythmias are not known. It is also not clear what factors may predispose certain individuals to arrhythmias. This study was designed to determine if Phase I cancer chemotherapeutic agents induce ventricular arrhythmias, to determine the time course of ventricular ectopy and to determine what risk factors may predispose certain patients to the development of ventricular arrhythmias.

METHODS

Patient Selection

A total of 55 patients (31 males and 24 females) were studied. Each had continuous 24-hour Holter monitoring on the first day of their first course of intravenous cancer chemotherapy and each gave written informed consent. The drugs administered were homoharringtonine in 33, mitoxantrone in 10, deoxycoformycin in four, aclacinomycin in three, MVE-2 in two, aziridinyl benzoquinone in two and etoposide in one. All patients were hospitalized at the time of the administration of these agents and a diary was kept by the patient and nursing staff. The diary noted patient activities, the time of administration of drugs, pain, nausea, vomiting and other symptoms such as chest pain.

Protocol

This study was divided into three parts. The first part consisted of 24-hour monitor recordings of 33 patients to determine the time course of ectopy. In the second part of this study the effect of chemotherapy versus that of placebo on the amount of ectopy was investigated. Information from the first part of the study was utilized in that we compared arrhythmias in the first two hours. The order of administration of saline or chemotherapy was randomized and the patients and investigators were blinded to the order of administration. The third part of the study was a retrospective review of the 55 patients to determine what factors might predispose patients to arrhythmias. Cardiac function, heart rate and QT intervals were measured to determine their relationship to ventricular arrhythmias.

Time Course of Arrhythmias

A free flowing intravenous line to be used for the administration of chemotherapy was begun. A cardiac monitor (Del Mar Electrocardiocorder Model 445B) was placed on each patient. After a two-hour base line recording, the chemotherapeutic agent was administered. The diary was used to record the exact time of the administration of the chemotherapy as well as to record any symptoms. No other chemotherapeutic agents were given concurrently. After the 24-hour recording the monitor was removed and the tape evaluated on a Del Mar Electrocardioscanner DCG VII "Trendsetter." The technician reviewing the tapes was blinded to the time and type of chemotherapy given. A print-out was generated that recorded the frequency and severity of arrhythmias.

Part II

In the second section of this study, a cardiac monitor was placed on the patient after a free-flowing intravenous line had been established. Two syringes were prepared and labeled. One contained the chemotherapeutic agent to be given and the other a equal volume of normal saline. The order of administration of placebo or chemotherapy was randomly assigned and the patient and chemotherapy nurse were blinded to the order of administration. The two injections were given at least two hours apart. The monitoring was continued for a full 24 hours. After 24 hours, the monitor was removed and the tape evaluated on the electrocardioscanner by a blinded technician. Again the frequency and severity of arrhythmias during each hour were evaluated.

Part III

A retrospective chart review of these 55 patients was used to determine the effect of cardiac function, heart rate, QT intervals and type of chemotherapy on arrhythmias. The ratio of the pre-ejection period to left ventricular ejection time of the systolic time intervals was used as the measure of left ventricular performance.[6] Normal function was defined as a ratio of $<.42$ and was found in 25 patients. Fourteen patients had a ratio $>.42$.

The base line heart rate was determined from the Holter monitor strips of patients resting prior to the administration of the chemotherapy. Fifty patients had a measurable QT interval from their electrocardiogram and this was corrected for heart rate.[7] Twenty-four of these patients had a normal QT interval at base line and their QT remained normal after chemotherapy. A second group of nine patients had a prolonged QT interval at base line but the QT interval did not become any longer after chemotherapy. A third group of 17 patients had normal or minimally prolonged QT intervals at base line; however, this group lengthened their QT by at least 20 msec after chemotherapy. Lastly, a comparison was made between the different types of chemotherapeutic agents. An adequate number of patients for comparison were available only for the homoharringtonine and mitoxantrone chemotherapeutic groups.

Statistics

Analysis of variance was used to compare the frequency of arrhythmias in the various time intervals after the administration of the chemotherapeutic agents in part I of this study. The frequency of arrhythmias recorded after placebo and chemotherapeutic administration in part II of this study were compared by the Student's T test for paired data. In the third part of the study a comparison of cardiac function, heart rate, QT interval and type of chemotherapeutic agent were compared by the Student's T test for unpaired data.

RESULTS

In the initial part of the study 33 patients were assessed to determine the time period in which most arrhythmias occurred. Premature ventricular contractions (PVCs) per hour occurred most frequently in the first two hours after chemotherapy. An average of 26% of PVCs occurred in this time period while the other 74% were scattered over the remaining 22 hours of monitoring. This was significant at a p value of <0.05. In addition, the frequency of PVCs was significantly greater ($p<0.05$) in the two hours after chemotherapy than the two-hour base line recording. Other arrhythmias recorded in addition to PVCs included non-sustained ventricular tachycardia; that is, ventricular tachycardia of >3 beats but <20 seconds in duration in two patients. However, one of these patients had the ventricular tachycardia recorded before the administration of the chemotherapeutic agent. The other episode of non-sustained ventricular tachycardia occurred four hours after the chemotherapy. One patient died during the monitoring period. This patient was terminally ill from his cancer and also had abnormal cardiac function. He had frequent PVCs noted soon after the administration of the homoharringtonine. The PVC did not diminish with time. Twelve hours after chemotherapy the QRS complex widened and two hours later he developed complete heart block followed by asystole. After 10 seconds of asystole he developed ventricular fibrillation. Cardiopulmonary resuscitation attempts were unsuccessful and an autopsy was not obtained. Four patients had supraventricular tachycardia. Two of these patients had supraventricular tachycardia in the first two hours after chemotherapy while the other two occurred three and five hours after chemotherapy respectively.

In the second part of the study, the effect of chemotherapy versus that of placebo on the number of PVCs was investigated. The number of PVCs in the two hours after administration of each regimen were counted. The average number of PVCs per hour after placebo was 3 ± 3 ($\pm$SD). This was not significantly different from the 6 ± 12 PVCs per hour recorded after chemo-

therapy. Six patients had more ectopy after chemotherapy; three had more PVCs after placebo. The other 13 patients either had no PVCs or an equal number of PVCs in the two time periods. One patient who had more PVCs after placebo also reported nausea during this time.

Thirty-nine patients had systolic time intervals recorded. Normal function was found in 25 patients who had an average of 4 ± 7 PVCs over the two hours after chemotherapy. The number in the two hours after chemotherapy for the abnormal function group was 18 ± 27 ($p<0.05$ different from normal). Of those with normal cardiac function, one had non-sustained ventricular tachycardia and two had supraventricular tachycardia after chemotherapy. Of the 14 subjects with abnormal cardiac function, two had non-sustained ventricular tachycardia and four had supraventricular tachycardia.

Resting heart rate was compared in the groups who had frequent PVCs defined as >20 PVCs in the two hours after chemotherapy versus those who had fewer than 20. The average heart rate of the group with frequent PVCs was 72 ± 8 beats per minute, and in the group with fewer PVCs the heart rate was 79 ± 9 (NS). When the groups were divided by heart rate (> or <75, > or <90), there was no significant difference in the number of PVCs in those who had a rapid heart rate as opposed to those with a normal or slow heart rate.

Fifty patients had a measurable QT interval from their Holter monitor strips. Twenty-four of these patients had a normal QT interval at base line and their QT remained normal after chemotherapy. The average number of PVCs in the two hours after chemotherapy for this group was 1 ± 2. None of this group had ventricular tachycardia. A second group of nine patients had a prolonged QT interval at base line but the QT did not become longer after chemotherapy. This group had 12 ± 12 PVCs in the two hours after chemotherapy and this was significantly greater than the normal QT interval group. In addition, two of these nine subjects had non-sustained ventricular tachycardia. A third group of 17 patients had normal or minimally prolonged QT intervals at base line, but lengthened their QT by at least 20 msec after chemotherapy. This group averaged 24 ± 54 PVCs in the two hours after chemotherapy, and this was also significantly different from the first group at a $p<0.05$. Two members of this group had non-sustained ventricular tachycardia, and the one patient who died belonged to this subgroup.

The last comparison was made between the different types of chemotherapeutic agents. No significant difference in the number of PVCs existed between the patients who received homoharringtonine versus those who received mitoxantrone.

DISCUSSION

This study has revealed that most but not all of ventricular ectopy occurs in the first two hours after chemotherapy. Although quantitatively this seemed to be true, some serious arrhythmias developed later in several patients, including one patient who developed heart block, asystole and ventricular fibrillation. Thus, it does not appear that patients who survive the first two hours after chemotherapy will have no further complications.

Although it is not clear what causes the PVCs after chemotherapy, it would appear to be as much due to the stress and/or anxiety as it is to the chemical compound. There was not a statistical difference between the placebo and chemotherapy treatment on the incidence of arrhythmias. That stress may be playing an important role in the post-chemotherapy arrhythmias is supported by the known association of stress with arrhythmias in sudden death.[7] It appears that psychological stress lowers the vulnerable period threshold for ventricular arrhythmias.[8] Underlying depression may only worsen the problem. Depression plus anxiety initiates a significantly higher arousal than anxiety alone and the arousal diminishes more slowly.[9] Thus, the depressed cancer patient who is receiving a chemotherapeutic agent for the first time may have a propensity to develop arrhythmias.

Certain risk factors did reveal themselves as predisposing individuals to the development of PVCs and worse arrhythmias. These risk factors included a prolonged QT interval or a QT interval that became long with chemotherapy and abnormal left ventricular function. Prolongation of the QT interval has been associated with malignant arrhythmias whether the QT prolongation is primary (Jervell-Lange-Nielsen or Romano-Ward)[10] or secondary to medications, electrolyte disturbances, central nervous system lesions, autonomic dysfunction[11] or ischemic heart disease.[12] One of the factors in the prolongation of the QT interval may be increased sympathetic tone.[13] Schwartz and Wolf[14] have noted that anxiety after a myocardial infarction may be associated with a prolonged QT interval, malignant arrhythmias and sudden death. Thus, the previously mentioned psychological states of the cancer patient may manifest arrhythmias by a prolonged QT interval. The importance of the QT interval in our study can be emphasized by the fact that all serious arrhythmias occurred in patients who had a prolonged QT interval either before or shortly after their cancer chemotherapy. No patient with a normal QT interval developed a serious arrhythmia.

Poor cardiac function is a risk factor for sudden death in coronary artery disease[15] and is also an indicator of a poor prognosis in dilated cardiomyopathy.[16] The present study has demonstrated that poor ventricular function is also a risk factor for the development of ventricular arrhythmias after the administration of Phase I cancer chemotherapy. In addition, the one patient who died had depressed left ventricular function as well as a prolonged QT interval.

This study has important implications for the administration of chemotherapeutic agents. The first is that the anxiety induced by these agents should not be underestimated by the oncologist. It may be that a thorough explanation and reassurance about a chemotherapeutic agent can decrease the incidence of ventricular arrhythmias. The second important implication is that certain identifiable risk factors predispose subjects to the development of arrhythmias. The most important of these risk factors is that of a prolonged QT interval or a QT interval that becomes prolonged after the administration of the chemotherapeutic agent. Abnormal cardiac function is also an important predisposing factor to arrhythmias.

It is the recommendation of this laboratory that patients receiving chemotherapeutic agents be well-informed of their nature and that they be reassured prior to and during the administration of the chemotherapy. Also, an electrocardiogram with measurement of the QT interval and cardiac function studies should be obtained prior to the administration of chemotherapeutic agents. Patients who have a prolonged QT interval or who have abnormal cardiac function should be closely monitored. While new chemotherapeutic agents should be closely screened for their potential effects on cardiac rhythm and function, observed changes might be due to other factors (e.g., anxiety and depression) rather than the biochemical effect and must be carefully interpreted.

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PREMENSTRUAL SYNDROME: ANSWERS TO COMMONLY ASKED QUESTIONS

William A. Price, MD
Lynn R. DiMarzio, MS
Pamela R. Gardner, RN

Premenstrual tension (PMS) is a collection of behavioral, psychological and physical symptoms that occurs repetitively every 28 to 30 days. PMS is a syndrome that afflicts a great number of women in varying degrees; nonetheless, it remains a disease that is surrounded by numerous myths and misconceptions. Only recently are some of these myths being challenged by facts, thereby helping alleviate some of the anxiety and symptomatology encountered premenstrually.

Premenstrual syndrome (PMS) is a term first coined by Frank in 1931 to describe the complex collection of behavioral, psychological and physical symptoms that occur repetitively during the premenstrual phase of a woman's reproductive cycle. Since then, numerous theories on both the etiology and treatment of this perplexing disorder have been proposed, none of which have yet been firmly established. Additionally, many myths and misconceptions concerning menstruation and PMS have arisen leading to increased anxiety and premenstrual symptomatology in some women. Physicians may also harbor these beliefs, thereby adding to their female patients' worries. Several questions regarding PMS are quite common. We present such a list that we are frequently asked in our practice and offer answers that may help remove some of these myths.

William A. Price, MD, Clinical Fellow Psychiatry; Lynn R. DiMarzio, MS, Clinical Research Associate; and Pamela R. Gardner, RN, Clinical Research Associate, all of Northeastern Ohio Universities College of Medicine, Rootstown, Ohio.

What is PMS?

Premenstrual syndrome is a collection of over 150 psychiatric and physical symptoms that occurs repetitively every 28 to 30 days in women of childbearing years. The most common symptoms include bloating, breast tenderness, weight gain, edema, headache, cravings for high carbohydrate or salty foods, fatigue, tension, irritability, depression and frequent mood swings. The three symptoms constituting the core of the syndrome are irritability, depression and lethargy. Since girls frequently experience menarche at age 13 and continue menstruating until menopause at age 45, women affected with this disorder can have as many as 380 episodes in their lifetime. Not all women are affected; those that are can have a variety of symptom combinations and can be classified as mild, moderate or severe sufferers. Some of the more severe PMS sufferers are held responsible for many of the sensational headlines that get printed such as increased rates of medical and psychiatric hospitalizations and suicide attempts, increased incidence of child abuse, and increased absenteeism from work, all occurring during the 10 to 14 days prior to menses in these affected individuals.

What is the incidence of PMS?

Because of the absence of universal criteria that can be used to define PMS, several studies reporting on the incidence of PMS have yielded a wide range of data. The most recent studies place the incidence ranging from as low as 30% to as high as 95%. What seems to be a conservative estimate, however, is that between 70 to 90 percent of the female population in the United States report recurrent premenstrual symptoms, while 20 to 40 percent report some degree of temporary mental or physical incapacitation. Thus most women in various degrees will experience premenstrual and menstrual symptomatology.

What causes PMS?

Several theories have been proposed to explain the etiology of PMS; as of yet, no single theory has received universal ac-

ceptance. There are those who still believe that PMS is a totally learned phenomenon passed on from generation to generation and bolstered by cultural taboos which tend to depict menstruation negatively. Others feel that PMS is "all in a woman's head" and view it as psychogenic in origin. Both these theories are falling out of favor, although there are those who steadfastly cling to these beliefs. The more popular theories include estrogen excess, progesterone deficiency, pyridoxine deficiency, excessive prolactin levels and endorphin withdrawal. Based upon the various biologic theories, several different pharmacologic treatments have been proposed.

What is the best way to diagnose PMS?

All things considered, the best means of establishing the diagnosis of premenstrual tension continues to be through the performance of a careful history and physical examination. Other possible causes of the emotional and physical changes encountered in PMS should be ruled out first. A careful reproductive history, including age of menarche, frequency and characteristics of menstrual periods, pregnancies and use of contraceptive methods should be taken for every woman. Research has revealed that PMS increases in incidence as parity and age increase; additionally, oral contraceptive use can effect premenstrual symptomatology. Questions regarding absenteeism from work, monthly changes in behavior, including appetite and sleep patterns, should be asked. Because PMS is associated with lack of exercise, an assessment of daily activities should be made. One of the best ways to gather this information is by having the patient keep a daily diary of mood, behavior and physical changes that occur for several cycles. Questions regarding a woman's own feelings about menstruation (i.e., is it a curse or a blessing?) should also be asked at this time. Family history of psychiatric or physical illnesses, including past cases of PMS, should be gathered as well as a family's attitudes toward menstruation. Finally, both a careful mental status examination and a physical examination should be carried out to rule other possible psychiatric or medical illnesses responsible for the symptoms.

Are there any tests that can be done to see if a woman really has PMS?

Several questionnaires have been developed by researchers which are aimed at separating women with varying degrees of premenstrual tension from those who are not affected. These questionnaires, while serving the purpose of aiding research, vary greatly from one another; and, as of yet, no single questionnaire has been all encompassing. These questionnaires are subjective and rely totally on the self-report of symptoms by women and therefore may be biased by over-reporting of symptoms.

Laboratory tests can also aid in the diagnosis, but the diagnosis of PMS should never be made on the basis of laboratory testing alone. Laboratory abnormalities that have been associated with PMS include increased estrogen, decreased progesterone, deficiency of pyridoxine, increased prolactin, hypoglycemia, decreased beta-endorphins, increased MHPG (3-methoxy-4-hydroxyphenyl glycol, the principle metabolite of central nervous system norepinephrine) during the late luteal phase of the menstrual cycle, decreased MHPG two days prior to menses, and then elevated MHPG during the menses.

What are some of the psychological variables associated with PMS?

Some of the earlier studies, circa 1950, failed to establish a significant correlation between PMS symptomatology and psychological disorders. Most recently, investigators have been successful in finding significant yet low correlations. For example, several studies have indicated that women who score high on tests measuring PMS severity also score high on standardized psychological tests measuring neuroticism (i.e., Eysenck Personality Inventory), tests measuring anxiety and psychosomatic symptoms (i.e., Minnesota Multiphasic Personality Inventory), and tests measuring levels of depression (i.e., Beck Depression Inventory). Although the research seems to establish a link between PMS and neurotic personality manifestations, it is important to note that studies have also found groups of extremely neurotic women who did not suffer from PMS. To date, the psychological research on PMS is inconclusive, replete with contradictory findings, and has not been able to clearly establish general relationships between PMS, personality disorders or psychiatric diagnostic categories.

What are some of the social, cultural and religious variables associated with PMS?

Some recent sociological/psychological studies have concluded that "traditional women" who accept conventional feminine stereotypes, as well as women who see themselves as maternal, are more likely to report higher levels of PMS symptomatology than their non-traditional, career-oriented counterparts. The research indicates that the "sick role" is comparable to the traditional role, and that illness behaviors may be a more viable coping mechanism for women in traditionally limited roles. Several studies have demonstrated that women who are high on Type A behavior (active, assertive, achievement-oriented) were less likely to report PMS symptoms. The researchers hypothesize that Type A women may actually ignore symptoms in order to carry on with their numerous daily activities. A number of recent studies have reflected the moderating role of religious factors in the experience of PMS. Some studies have indicated that Catholic women as a group experience the highest level of PMS and are followed in descending order by Jewish and Protestant women. Catholic women who adhered to the traditional female role experienced the most distress. Among Jews, menstrual taboos and rituals (i.e., abstaining from sex during menstruation, engaging in hygienic rituals during menstruation) were factors associated with menstrual and premenstrual distress. A few investigators have conducted epidemiological research on PMS. While their findings are tentative, the research suggests that women who are better educated, employed, and earn more income reported few PMS symptoms.

What can be done to treat PMS?

Studies reporting on the treatment of PMS must be viewed cautiously. The majority of studies are uncontrolled and contain serious methodological flaws such as lack of placebo control groups, failure to employ a double-blind crossover design, and failure to define PMS appropriately. Keeping all this in mind, no single treatment has consistently proven to be effective in relieving premenstrual and menstrual symptomatology, although the list of pharmacological treatments is quite extensive. The most promising medications include estrogen and progesterone, oral contraceptives, pyridoxine, bromocriptine, clonidine and verapamil. In the past, the best that could be offered the PMS sufferer was a drug combination consisting of diuretics for the bloating and breast tenderness, analgesics for the abdominal cramping, and minor tranquilizers and barbiturates for the emotional changes; however, these treatments are being employed less frequently as the above mentioned treatments gain acceptance.

What is the role of estrogen and progesterone in the pathogenesis and treatment of PMS?

During normal menstruation, estrogen levels reach their peak at ovulation and then fall, whereas progesterone begins a corresponding rise during the luteal phase. Menses occurs when hormonal support to the growing endonetrium is abruptly withdrawn. This rise and fall of hormones is accompanied by similar changes in neurotransmitters such as endorphins, which are known to co-vary with estrogen levels, or MHPG, which has a similar waxing and waning course. The precise relationship between estrogen, progesterone, neurotransmitters and the symptoms encountered in PMS remains unclear.

Frank, the man responsible for coining the work premenstrual tension syndrome in 1931, was the first to propose that excessive female sex hormones were responsible for PMS. Some

Premenstrual Syndrome . . . continued

researchers have suggested that an accumulation of estrogen within the limbic system of the brain is responsible for the central nervous system manifestations of PMS. On the other hand, the use of progesterone, usually administered intramuscularly or by rectal or vaginal suppositories, to antagonize unopposed estrogen has also been used to treat PMS. This form of therapy is quite popular, especially in women's magazines, and has been publicized by Dalton in England, although the studies to date have been poorly documented.

What is the role of contraceptive use in the experience of PMS?

Some recent studies show that women taking oral contraceptives experience less symptoms than non-users. Some differences were also found with regard to peak demonstration of negative effect: women who did not use oral contraceptives peaked during the menstrual phase, whereas women using contraceptives peaked in their premenstrual phase. In a well-designed double-blind crossover study, it was found that oral contraceptives reduced some types of symptoms (pain, behavioral change, irritability), but exacerbated other symptoms (water retention, painful breasts, nausea). The use/non-use of oral and intrauterine contraceptives has not been controlled as a variable in many studies conducted to date. This creates serious methodology concerns and renders such research tentative at best.

How is pyridoxine involved?

Pyridoxine or vitamin B6 serves as a co-factor, pyridoxyl phosphate, in the synthesis of dopamine, norepinephrine and serotonin, the neurotransmitters that appear to be responsible for controlling effect and cognition. Pyridoxine levels have been known to be abnormally low in oral contraceptive users, often giving rise to a depression that responds to B6 supplementation. It is believed that in PMS sufferers a relative decrease in pyridoxine decreases dopamine production thereby increasing prolactin and giving rise to symptoms. Although studies to date have employed different doses of pyridoxine, the usual dose is 500 mg daily. This is well tolerated and has been fairly successful at decreasing premenstrual dysphoria and physical symptoms. Care should be exercised not to exceed 500 mg a day since toxic side effects such as peripheral neuropathies have been reported when excessively high doses, 2 gm/day, have been employed.

How is bromocriptine used to treat premenstrual symptomatology?

Bromocriptine is a dopamine receptor agonist that inhibits prolactin secretion. High levels of prolactin, usually in the upper limits of normal, have been associated with PMS. Additionally, it appears that more symptomatic PMS sufferers have a greater luteal phase increase in prolactin secretion than their asymptomatic counterparts. Bromocriptine has therefore been used with good results, usually in a dose range of 1.25 mg twice a day to 5 mg a day, to treat the premenstrual symptoms of irritability, mastodynia and weight gain.

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Also cited for outstanding accomplishments were the Committee on Geriatric Medicine and its efforts to identify and assist needy, elderly citizens; the OSMA Auxiliary under the superb leadership of Dee Talmage; the Annual meeting, specialty society, and continuing medical education programs; the Physician Effectiveness Program and its ongoing outreach to impaired physicians; the OSMA Ombudsman Program to assist physicians entangled in bureaucratic red tape in government medical programs and with third party carriers; and the OSMA membership and fiscal programs.

Dr. Abromowitz had high praise for the first-year accomplishments of the new OSMA staff management team — Executive Director Herbert E. Gillen and Managing Director D. Brent Mulgrew, J.D. — as well as for other members of the OSMA staff.

Looking ahead, Dr. Abromowitz expressed deep concern over the nationwide drive for lower health care costs at the expense of quality. He emphasized that quality is the bottom line — and that physicians must make certain that patients receive the best possible health care.

In conclusion, Dr. Abromowitz said, "Let us as physicians, the greatest ally and advocate for our patients, ensure that quality medical care is first, foremost and always."

The House accepted the report by acclamation and it was filed.

RESOLUTION NO. 44-86
National Eye Care Project

The Committee has placed this resolution on the **Consent Calendar and recommended its adoption.**

RESOLVED, That the Ohio State Medical Association commend the Ohio Ophthalmologists who are participating in the National Eye Care Project.

By consent, **the House adopted Resolution No. 44-86.**

RESOLUTION NO. 45-86
Eye Safety

The Committee has placed this resolution on the **Consent Calendar and recommended its adoption.**

RESOLVED, That the Ohio State Medical Association encourage its members to educate their patients to wear safety lenses or goggles while operating equipment in home workshops, for lawn care, hunting or any other activity that may prove hazardous to their eyesight.

By consent, **the House adopted Resolution No. 45-86.**

THE REPORT OF RESOLUTIONS COMMITTEE NO. 3, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

Inaugural Ceremony

Dr. Frank H. Mayfield escorted Mrs. Albers and their children to the rostrum. Dr. Albers escorted his mother and father to join them.

Dr. Payne administered the Presidential Oath of Office to Dr. Albers. Dr. Albers introduced the members of his family to the House. He also introduced other relatives, close friends and associates seated in the audience.

Dr. Abromowitz then presented to Dr. Albers the official gavel and the President's Medallion. Dr. Albers addressed the House.

The Albers family was given a standing ovation.

Dr. William J. Marshall escorted Mrs. Abromowitz to the rostrum.

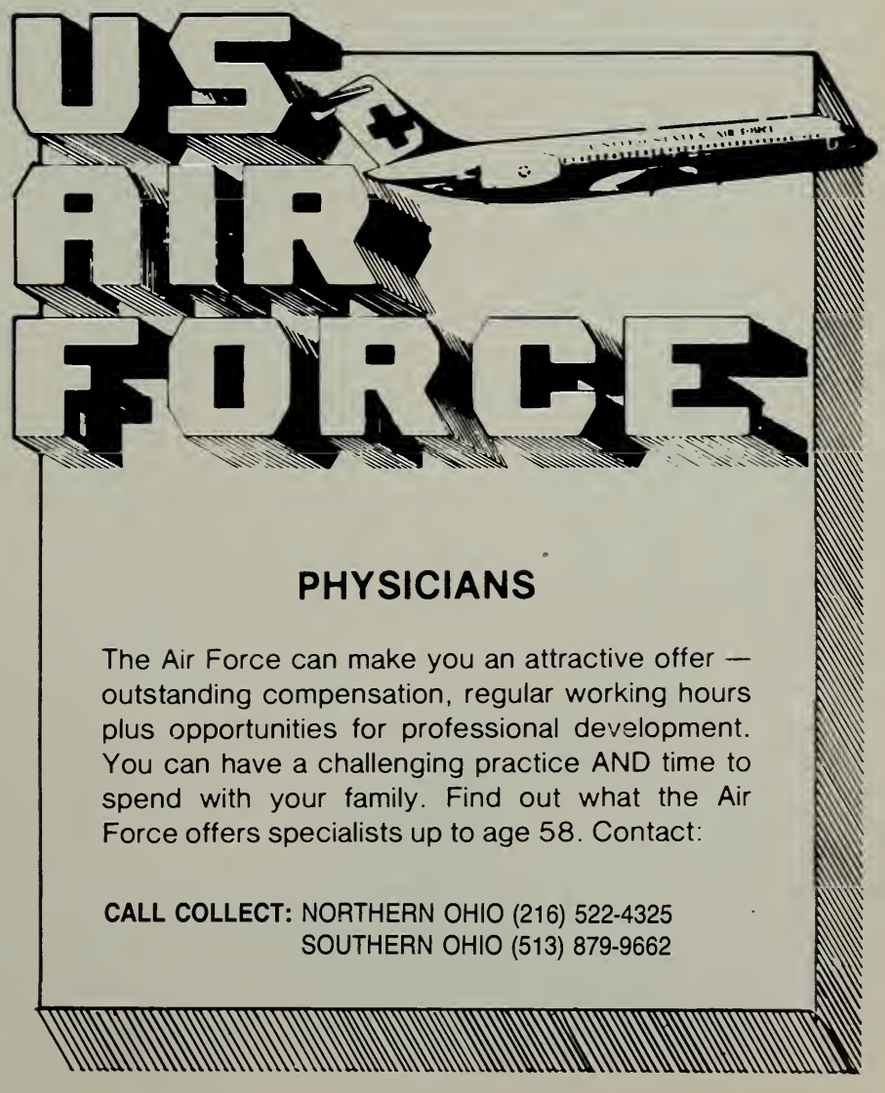
Dr. Albers presented to Dr. Abromowitz the past president's pin, the president's plaque, a replica of the president's medallion to Mrs. Abromowitz and a replica of the president's medallion to Dr. Abromowitz. Dr. Albers then presented a personal gift to Dr. Abromowitz.

Dr. Abromowitz addressed the House expressing his thanks for the support given to him during his year as President.

The House gave Dr. and Mrs. Abromowitz a standing ovation.

There being no further business, the House of Delegates adjourned, sine die.

ATTEST: Herbert E. Gillen
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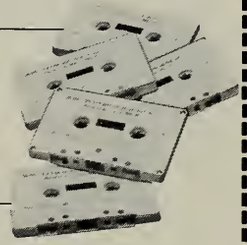
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Obituaries

WILLIAM A. BLANK, MD, Toledo; University of Nebraska College of Medicine, Omaha, Nebraska, 1943; age 72; died May 23, 1986; member OSMA and AMA.

CHARLES A. CLIFTON, MD, Chillicothe; Ohio State University College of Medicine, 1944; age 67; died May 24, 1986; member OSMA.

EDWARD DROHAN, MD, Cincinnati; University of Cincinnati College of Medicine, 1937; age 85; died May 17, 1986; member OSMA and AMA.

WILLIAM B. FAIRCLOTH, MD, Zanesville; Tulane University School of Medicine, New Orleans, Louisiana, 1932; age 79; June 1, 1986; member OSMA and AMA.

THOMAS A. GARDNER, MD, Columbus; University of Cincinnati College of Medicine, 1941; age 67; died June 5, 1986; member OSMA.

JOHN E. GILLETTE, MD, Versailles; State University of New York Upstate College of Medicine, Syracuse, New York, 1922; age 88; died May 11, 1986; member OSMA and AMA.

OLIVER ADOLPH HORAK, MD, Ft. Myers, Florida; University of Nebraska College of Medicine, Omaha, Nebraska, 1943; age 69; died March 11, 1986; member OSMA and AMA.

HENRY G. LEHRER, MD, Manistee, Michigan; Ohio State University College of Medicine, 1936; age 74; died May 20, 1986; member OSMA.

BREAUX F. MARTIN, MD, Toledo; Meharry Medical College, Nashville, Tennessee, 1939; age 74; died May 28, 1986; member OSMA and AMA.

ALAN R. MORTIZ, MD, Chagrin Falls; University of Nebraska College of Medicine, 1923; age 86; died May 12, 1986; member OSMA and AMA.

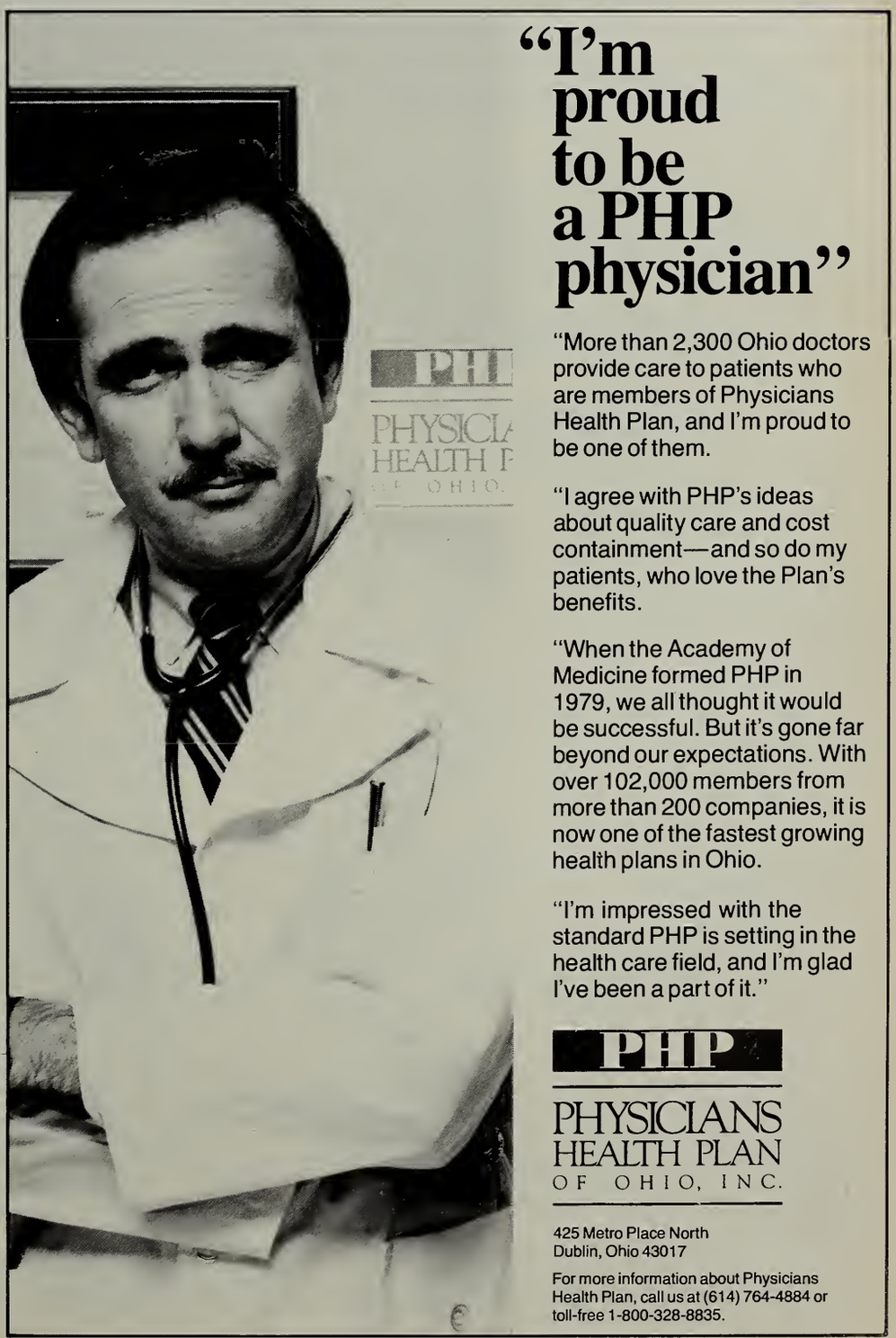
MERRILL D. PRUGH, MD, Dayton; Hahnemann Medical College of Philadelphia, 1909; age 102; died May 24, 1986; member OSMA and AMA.

REED CLAYTON PRUGH, MD, Evart, Michigan; University of Michigan Medical School, Ann Arbor, Michigan, 1938; age 73; died May 16, 1986; member OSMA and AMA.

JOSEPH M. ULRICH, MD, Akron; Case Western Reserve University School of Medicine, 1916; age 96; died May 29, 1986; member OSMA and AMA.

ERNEST R. VALENTINE, MD, Alliance; Medizinische Fakultaet der Universitaet, Rostock, Germany, 1926; age 85; died May 8, 1986; member OSMA and AMA.

SAMUEL VOLK, MD, Cleveland; Case Western Reserve University College, 1920; age 92; died April 27, 1986; member OSMA and AMA.



Continued from page 556

Why are clonidine and verapamil useful in treating PMS?

Clonidine, a centrally acting alpha-2 noradrenergic agonist, is most commonly used as an antihypertensive medication; however, due to its inhibitory action on presynaptic neurons, it has been used to treat anxiety, mania, psychosis and opiate withdrawal. Clonidine has also proven to be successful in treating severe dysmenorrhea accompanied by nausea and vomiting and also post-menopausal flushing. Several of the symptoms of PMS resemble those of opiate withdrawal such as abdominal cramping, mood swings and irritability. The same mechanism, beta-endorphin withdrawal, has been implicated for both processes. In severe PMS sufferers, beta-endorphin levels have been found to undergo a statistically significant withdrawal compared to mild sufferers. Clonidine in doses of 0.1 mg three to four times a day has proven to be effective in decreasing premenstrual symptomatology.

Verapamil is a potent calcium channel blocker used primarily as an anti-anginal and anti-arrhythmic. It has recently been used with increasing success to treat psychiatric disorders such as mania and schizophrenia. Verapamil inhibits neurosecretory processes including excitation-secretion coupling of adrenergic and cholinergic synapses, thereby decreasing hypernoradrenergic tone. Premenstrual tension is associated with hypernoradrenergic tone and has responded to verapamil at doses of 80 mg four times a day.

Can anything else be done?

Empathic understanding still remains the key in helping the PMS sufferer cope with these cyclical mood swings. Relaxation techniques can reduce anxiety and decrease the pain. Women who are physically more active suffer less from PMS; therefore, a daily regimen of exercise can help decrease menstrual and premenstrual symptomatology. Additionally, dietary restriction of salt and high carbohydrate foods, especially during the ten days prior to menses, can significantly decrease bloating and cramping.

PMS is a complex disorder. No single theory has yet to explain its development totally. It appears that several factors either separately or in combination can be held responsible for PMS symptomatology. Approaching PMS biopsychosocially can help all those involved understand its pathogenesis as well as treatment. A unidimensional conceptualization of premenstrual syndrome is not adequate. Women experience varied degrees and types of premenstrual symptoms. Such differences may be accounted for on the basis of different biological, behavioral, affective, and attitudinal substrates. If one employs this same multi-dimensional approach in the treatment of PMS, then wholistic, empathic care can surely be offered to those women unfortunate enough to suffer from these cyclical changes.

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February 1985

THINK ECTOPIC PREGNANCY

Diane Duckworth, DO
Michael J. Eighan, MD
Pang-Hsiung Huang, MD

One hundred fifty-three consecutive cases of ectopic pregnancies in a university-affiliated community hospital from 1978-1983 were retrospectively analyzed. Reviewed were ages, parity and historical features including high-risk factors for ectopic pregnancy and prevalent symptoms with physical findings. Diagnostic modalities, ectopic site and presence or absence of rupture with definitive treatment were outlined.

The object of this study is to heighten clinical awareness of the many faces of ectopic gestation and to promote prompt diagnosis and treatment. By so doing, more conservative definitive surgery may be undertaken earlier to lessen the mortality and morbidity of the condition and to preserve future fertility.

Introduction

First described in the eleventh century,[1] ectopic pregnancy has become an increasingly more important clinical problem with which the health care professional, and system, must deal. Regional and national studies have confirmed a continued increase in ectopic gestation incidence since 1950 with a two- to three-fold jump during the decade of the 1970s, bringing a rate to 14.5 ectopics per 1000 live births in 1980.[2,3,4] Although death-to-case rates had declined from 3.5/1000 in 1970 to 0.9/1000 in 1978, ectopic gestation still remains as a major cause of maternal mortality accounting for 11.5% in 1978.[3]

Defined as embryonic implantation outside the uterine corpus, the most frequent location of ectopic pregnancies is the fallopian tube (95-97%), followed by the uterine cornu (2-3%), ovary (0.5%), cervix (0.1%), and abdomen (0.03%). Although the etiology is not fully known, investigators implicate three areas: 1) an abnormal or over-mature conceptus, 2) increased tubal receptivity (e.g., tubal endometriosis), and 3) altered tubal anatomy or physiology causing delayed passage of the conceptus.[5] Most experts agree that the latter of these is the most significant mechanism, accounting for most of the following risk factors for ectopic gestation: previous ectopic pregnancy, previous pelvic inflammatory disease (PID), prior tubal surgery, pelvic endometriosis, prior bilateral tubal ligation, intrauterine contraceptive devices (IUD), progestin-only oral contraceptives, previous elective abortions, and prior abdominal surgery.[5,6,7,8] PID is classically believed to be the major cause of ectopic pregnancy. Investigators point to the coincident dramatic increases in incidences for both diseases,[9,10,14] as well as the frequent finding of PID histories and PID-associated histologic changes in patients with ectopics.[10-13,19,23,24]

The clinical manifestations of ectopic pregnancy are notoriously protean, which, before the era of improved pregnancy tests and ultrasonography, led to correct initial diagnoses in only 57% to 67% of cases in some studies.[10,13] Symptoms and physical findings include abdominal pain (99%), abnormal uterine bleeding (74%), amenorrhea (68%), adnexal tenderness (96%), a unilateral adnexal mass (53%), and enlarged uterus (30%).[15] The differential diagnosis includes acute salpingitis, functional ovarian cyst, ovarian tumor, appendicitis, torsed adnexa, endometriosis, pelvic adhesions, fibroids, polycystic ovarian disease, cystitis, renal stone, and gastroenteritis.[3] Modern diagnostic tools including beta-subunit hCG, culdocentesis, ultrasonography, and laparoscopy enable the wary physician to diagnose ectopic pregnancy correctly.[20] Regarding tubal pregnancies, choice of surgical therapy, ablative (e.g., salpingectomy) as opposed to conservative

Diane Duckworth, DO, chief resident, Michael J. Eighan, MD, resident, and Pang-Hsiung Huang, MD, FACOG, FACS, St. Elizabeth Medical Center Department of Obstetrics/Gynecology, Youngstown, Ohio.

(e.g., salpingostomy), depends primarily on the extent of tissue involvement and the desire for future fertility. Conservative therapy is reserved for patients with unruptured tubal ectopic gestations who may have had a prior salpingectomy but still desire fertility. Several studies refute the accusations that this tubal surgery predisposes to recurrent ectopics.[16,17,18]

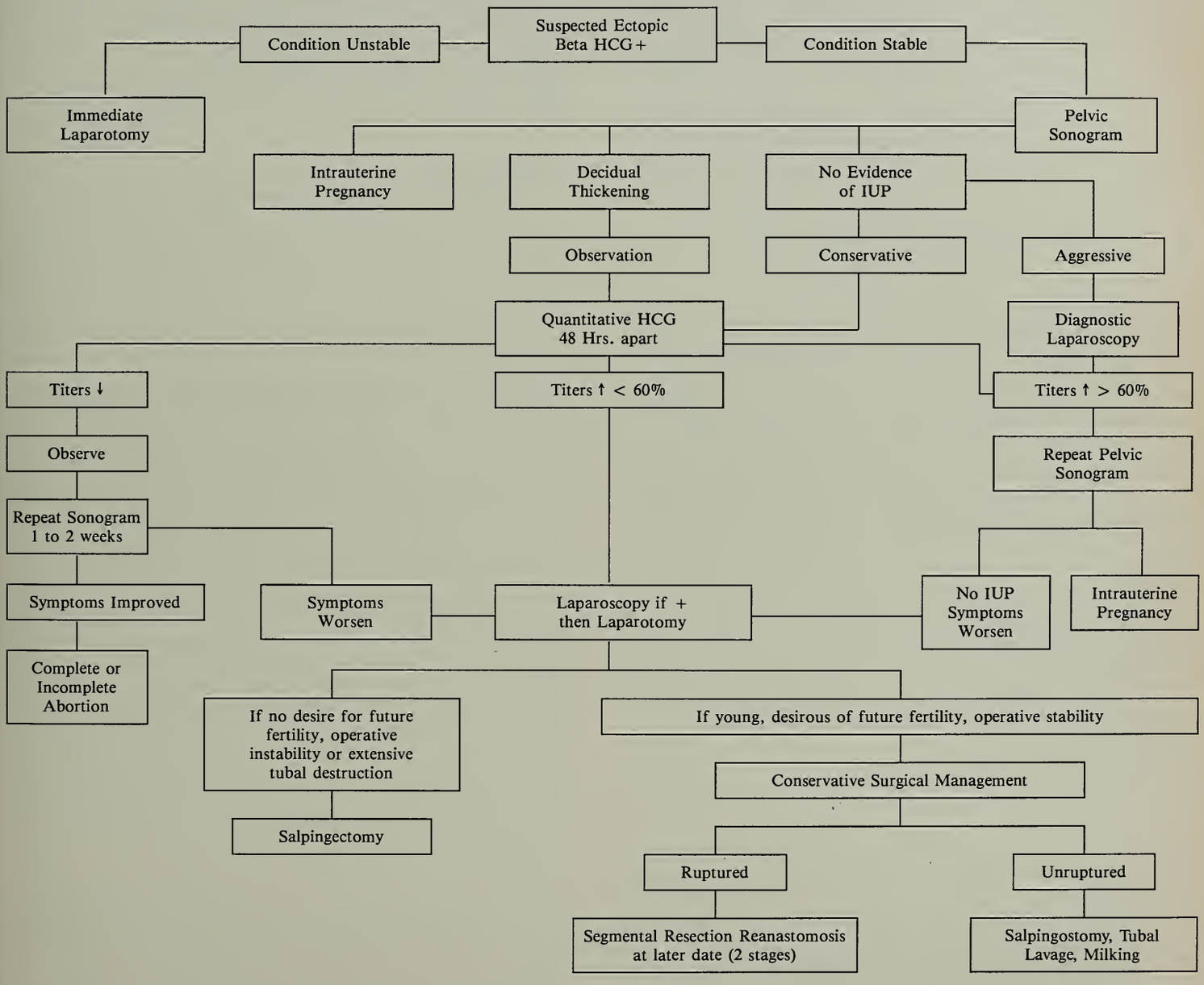
The present study is a retrospective analysis of ectopic pregnancies with regard to their presentation, evaluation and disposition. It is the goal of this study to heighten the awareness of the clinician toward understanding and suspecting the diagnosis of ectopic pregnancy in cases of women with abdominal complaints.

Age, population distribution, parity, high-risk factors

The majority of patients (67%) were within the childbearing years 20-29. Nine cases (6%) were adolescents aged 10-19 and 40 cases (26%) were aged 30-39. Only two patients were reported in the oldest age group (40-49) with ectopic gestations.

The population under study was distributed between 29 (19%) house patients and 124 (81%) private patients. Thirty-four (22%) patients had never been pregnant before, whereas 119 (78%) were multiparous. In the institution studied a general increasing trend was noted for all but the first year of the study, with a rate of 10.5 in 1978 to 17.2 in 1983. (Rates represent number of ectopics per 1000 live births.)

Diagnosis and Management of Suspected Ectopic Pregnancy



Results

The present study is based on a retrospective critical analysis of 153 consecutive ectopic gestations in 145 patients at St. Elizabeth Hospital Medical Center, a university-affiliated community hospital, from 1978 to 1983. The data reviewed included age, parity, population distribution, history of high-risk factors for ectopic pregnancy, presenting symptoms and physical findings and diagnostic procedures performed. In addition, the type of ectopic gestation, its site and evidence of rupture were noted as was the definitive procedure utilized for treatment and any complications encountered.

Seventy-nine (52%) had no pre-existing risk factors which are known to be associated with ectopic pregnancy. The highest risk factor noted in the population under study was a history of pelvic inflammatory disease, documented in 19 (12%). Eight percent of patients had had one or two prior ectopic pregnancies and 6% had an IUD in situ at the time of diagnosis. An additional 6% were initially misdiagnosed as threatened or incomplete abortions, underwent a dilatation and curettage, with resultant decidual tissue only reported on pathological diagnosis, thus directing further investigation into the detection of the ectopic. Five percent of patients had a history of infertility and 3% had a history of endometriosis. Five percent had previously under-

gone bilateral tubal ligation of undetermined method and 4% were using oral contraceptives at the time of the ectopic conception. In 2%, a tubal reanastomosis had been performed following a prior bilateral tubal ligation and another 2% had a history of cervical dysplasia with resultant biopsy or conization.

Clinical features on admission

A history of amenorrhea, abdominal pain, and abnormal vaginal bleeding were evaluated with physical signs of a detectable pelvic mass, increased uterine size, and any objective abdominal or pelvic tenderness on admission.

By far the most prevalent presenting symptom, in 142 patients (93%), was pain. The presence of abnormal vaginal bleeding was described in 101 patients (66%), and 90 (59%) had a history of amenorrhea.

Twenty-three patients (15%) were too tender for an adequate pelvic exam and, in fact, 125 patients (82%) were found to have some degree of tenderness exhibited on exam. Sixteen percent had an enlarged uterus from 6-12 weeks size and 27% had a pelvic mass detected. Either because of an obvious diagnosis in the face of an unstable patient or because another exam had been done by the patient's admitting physician immediately prior to admission, no pelvic exam was performed on 18% (28 patients).

In those patients examined, only 27 (18%) exhibited the classic triad for ectopic gestation of abdominal pain, abnormal bleeding, and a pelvic mass.

Diagnostic procedures

A urinary pregnancy test (UCG) sensitive to 500mIU/ml of human chorionic gonadotropin (hCG) was performed on 76 patients (50%) with a positive result in 34 of those done (22%).

Qualitative serum studies for βhCG, sensitive to 34 mIU/ml, were obtained on 97 patients (63%) with a positive result in 86 cases (56%). As of 1978, the institution's laboratory began processing quantitative levels of βhCG to 25 mIU/ml, and in the 30 cases (20%) in which this was done, 23% had evidence of sequentially increasing levels (i.e., less than 50% increase over 48 hours) in the presence of an ectopic pregnancy, whereas 37% evidenced decreasing quantitative βhCG titers prior to the diagnosis of extrauterine pregnancy.

Culdocentesis was performed on 44 patients (29%), and in 75% of those performed, 33 patients, a positive yield of clearly non-clotting blood was found.

A diagnostic laparoscopy was performed on 60 patients (40%), of which 48% (29 cases) revealed a ruptured ectopic pregnancy; but in 52% (32 cases), unruptured ectopic pregnancies were diagnosed. In one case the laparoscopy proved therapeutic in that it resulted in a laparoscopic suction of the extruded tubal gestation, precluding the need for a laparotomy.

In 104 of the 153 cases, pelvic sonograms were performed on one or more occasions as adjuncts to aid in the diagnosis. The most commonly reported sonographic findings in the cases studied were, in order, the presence of a pelvic mass (70%), the detection of a uterine midline echo (i.e., empty uterus) (45%), the presence of cul-de-sac fluid (28%), and an obvious enlargement of the uterus (12%). Three cases of an intrauterine gestation were mistakenly diagnosed by sonograms, including that of the advanced ectopic gestation reported.

Surgical findings

Sixty-five percent of the patients (99) had ruptured ectopic pregnancies with resultant hemoperitoneum. Fifty-four cases (35%) were unruptured.

Only the tube proper was noted as the ectopic site per the operative note in 42% (64 cases) without identification of the tubal segment involved either because the involvement was too extensive for localized identification or the pregnancy involved the tubal length in toto. Thirty-eight (25%) ampullary, 13 (8%) isthmic, and 10 (7%) infundibular pregnancies were reported. There were 22 (14%) fimbrial abortions and five (3%) cornual pregnancies. Only one ovarian pregnancy was found to have occurred during the years under study, and no further advanced gestations in the second trimester were noted other than the case reported.

Definitive operative procedures

The most commonly employed definitive procedure undertaken at the institution under study was unilateral salpingectomy in 86 cases (56%). In decreasing order of frequency, salpingo-ophorectomy was performed in 34 cases (28%), cornual resection in 10 cases (7%), and linear salpingostomy in eight cases (5%). Because of prior unilateral salpingectomy and with extensive destruction of the involved tube, a total abdominal hysterectomy with unilateral salpingectomy or salpingo-ophorectomy was performed in seven cases (5%). A tuboplasty or reanastomosis of the uninvolved tubal segments was done in five cases (3%). Because of a non-bleeding tubal abortion, no definitive procedure was done on two cases, and, as previously mentioned, a laparoscopic suction of extruded tubal contents was the definitive procedure in one case.

Complications

Complications ranged from concomitant urinary tract infections in eight patients to pulmonary embolli in two patients postoperatively. One hundred and twenty-nine total units of either whole blood or pack red blood cells were transfused into 44 patients, with an average requirement of two units in each case.

Discussion

Many studies point to the increasing incidence of ectopic gestation in the United States.[2,3,4] Despite the fact that the incidence of ectopics at St. Elizabeth Hospital Medical Center was less than the national average for two of the three later years where national data were available, it is the relative changes which are paramount in assessing local epidemiology. It is difficult to explain the relatively high initial ectopic rate in our study as more than a spuriously high value. Nonetheless, the overall relative increased incidence of 69%, with over a four-fold jump during the last five years of the study, are quite in line with national trends.

Most of the patients in the present survey (52%) as well as another study[25] had no evidence of any previously mentioned risk factors for ectopic pregnancy. However, among those in the high risk group, a history of PID was the most frequently implicated condition seen in 12%. Prior studies have shown somewhat higher figures, ranging from 8% to 53%.[11,12,22-25] The incidence of repeat ectopics in our study (8%) is also similar to other surveys.[11,22,24] Only about 30% of those with prior ectopics go on to deliver a live infant.[5,9] These and other risk factors noted in this study point to altered tubal function or anatomy in the etiology of ectopic gestation.

The presence of an IUD, as seen in 6% of our patients, presents a double risk not only in the possible development of infection,[19,25,26] but also in the increase of the relative frequency of ectopic gestation by effectively preventing intrauterine pregnancy.[27]

The protean nature of the clinical features in ectopic pregnancy are well known[5,25,29] and are supported by our findings. Pain and abnormal uterine bleeding are the most frequent symptoms. The classical triad of pain, abnormal bleeding and adnexal mass was present in only 18% of our patients. Diagnosis given nonspecific findings is based on a high level of clinical suspicion.

Various procedures made available within the past decade have helped to improve greatly the accuracy of diagnosis. The older urine pregnancy test by the agglutination method is notoriously insensitive, being reliable only above 500 mIU/ml, thus detecting only 50% of ectopic pregnancies prior to the fortieth day after the last menstrual period.[30] A newer urine hCG test,

a radioreceptor assay, improves the sensitivity to 95%, detecting as little as 50mIU/ml corresponding to the time of the first missed menses. The qualitative serum beta subunit hCG, a radioimmunoassay, is 98% sensitive, becoming positive at about 34mIU/ml, which is equivalent to 7-10 days post-conception.[5] By following quantitative beta-hCG levels, growth of the gestational tissue may be followed early in pregnancy. In early normal pregnancies, the serum hCG increases by greater than 50% every 48 hours. Absence of decreasing levels indicates persistent hCG-producing tissue is present, suggesting an ectopic. However, decreasing levels may also suggest an ectopic due to lack of adequate space for development of normal amounts of trophoblastic tissue in the tube.

Ultrasound is most useful in identifying normal intrauterine gestation evidenced by a gestational sac within the uterus, but it often finds evidence of an ectopic such as pelvic mass, presence of a midline uterine echo signaling an empty uterus and fluid in the cul-de-sac. If by the time beta-hCG levels are at least 6000 mIU/ml and no intrauterine gestational sac is seen, ectopic pregnancy must be strongly considered. Despite misinterpreting intrauterine pregnancies in three cases of ectopics, ultrasound proved to be of benefit in a majority of cases.

Visualization of the pathology via laparoscopy is the ultimate diagnostic modality in the clinically stable patient suspected of having an ectopic. Only 40% of cases in this study were subjected to laparoscopy, but it was not until the early years of our study that laparoscopy became widely used at this institution.

Choice of definitive surgical treatment depends upon the extent of involvement and desire for future fertility. Most patients had a simple unilateral salpingectomy (56%) in our study. When continued fertility becomes a major issue, conservative procedures including salpingostomy and segmental resection and reanastomosis of the involved tube may be performed as was done in 13 of our cases. These types of conservative tubal surgeries would seem to produce high repeat ectopic rates due to intrinsic or pre-existing tubal pathology as well as the surgically induced trauma. Several studies, however, show little difference between the recurrent ectopic rates of ablative tubal surgery and conservative tubla surgery performed with meticulous microsurgical techniques.[16-18] Figure 1 exhibits a suggested management flow chart to diagnose and manage a case of a suspected ectopic pregnancy.

In conclusion, ectopic pregnancy is a significant health care problem of increasing proportions, accounting for 11.5% of all maternal deaths in 1978. Dorfman's study claims that fully one-half of maternal deaths from ectopics might have been prevented with more prompt diagnosis and treatment. Additionally, it showed that deaths caused by unpreventable complications were uncommon.[31] Thus when faced with nonspecific abdominal or pelvic findings, the prudent physician must bear a high index of suspicion for ectopic pregnancy and act accordingly.

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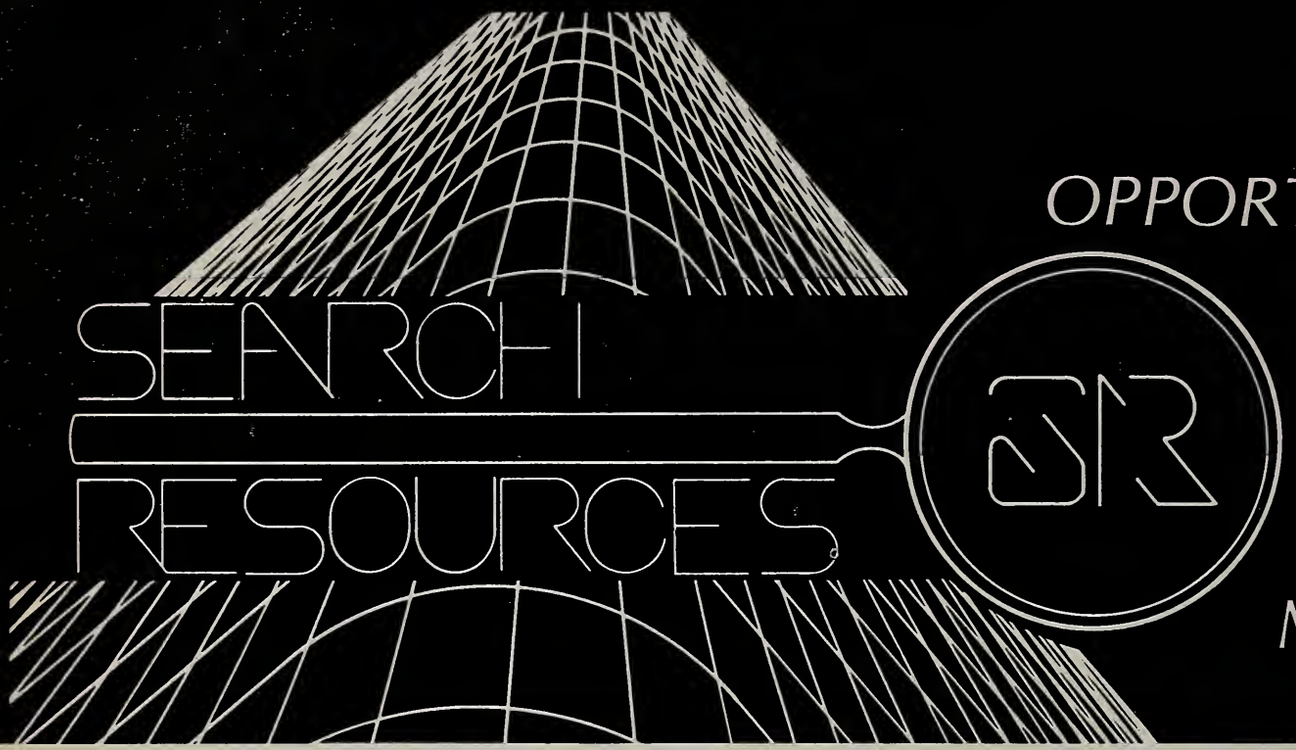
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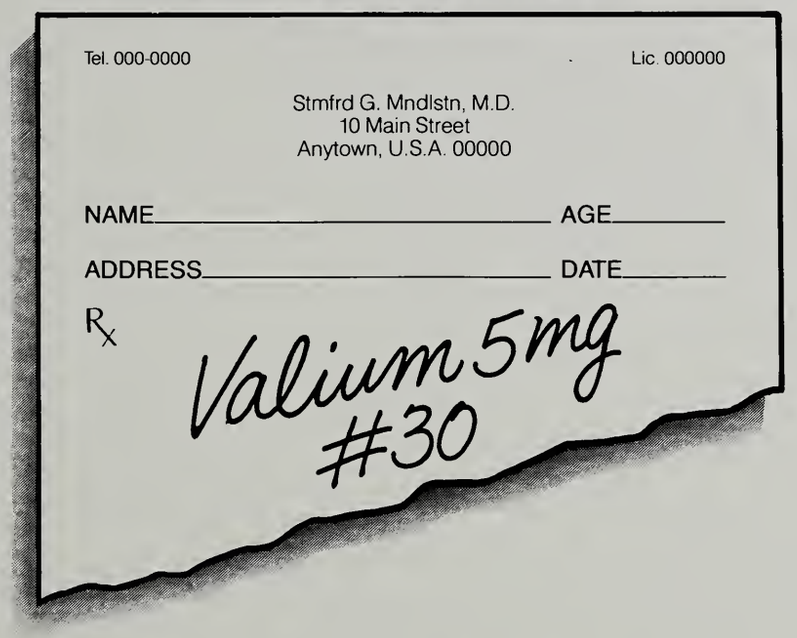
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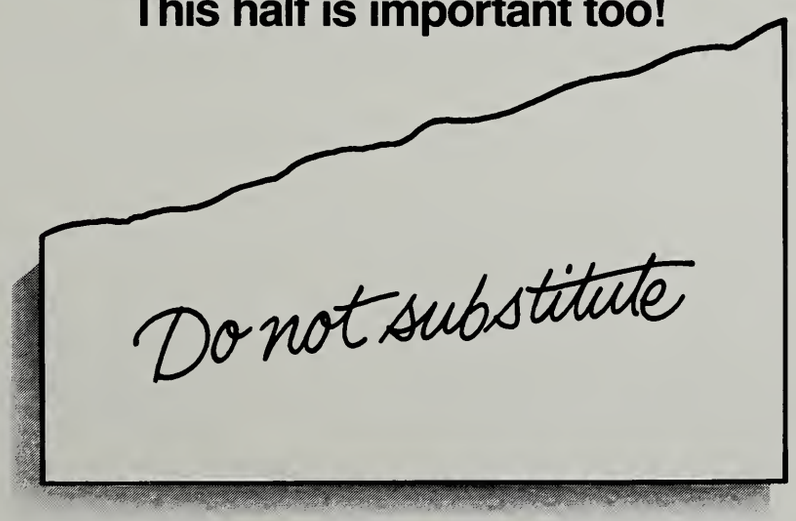
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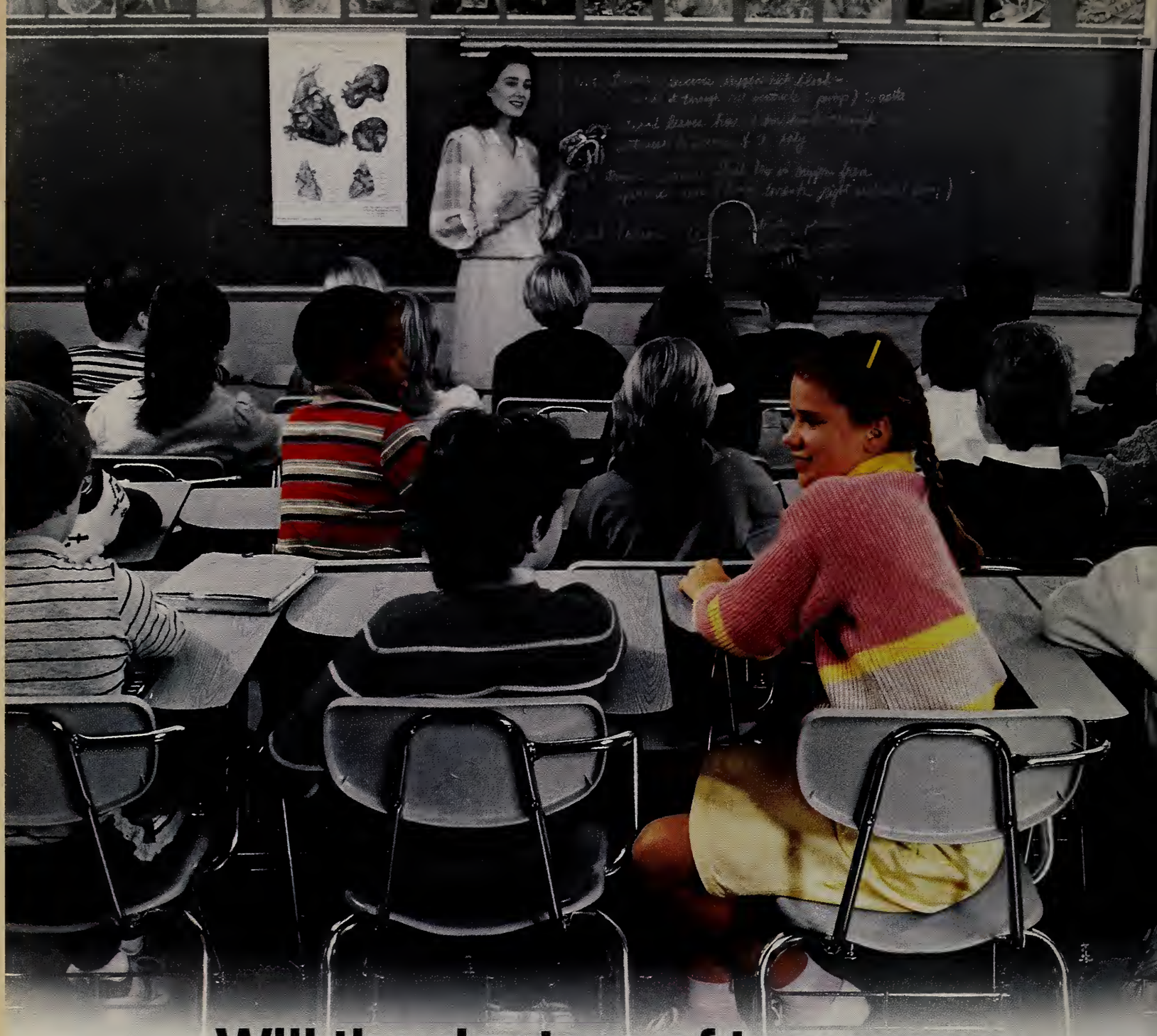


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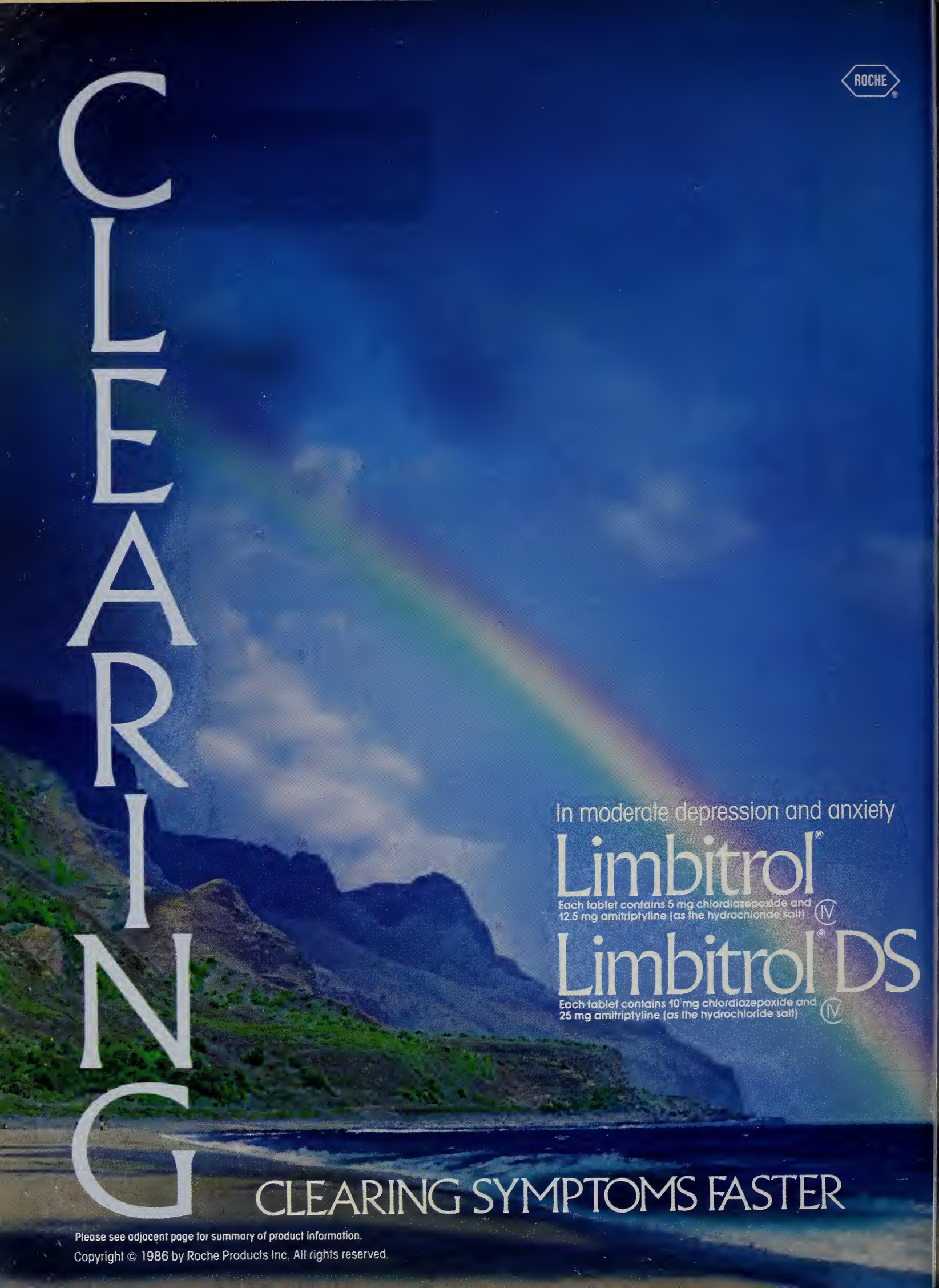
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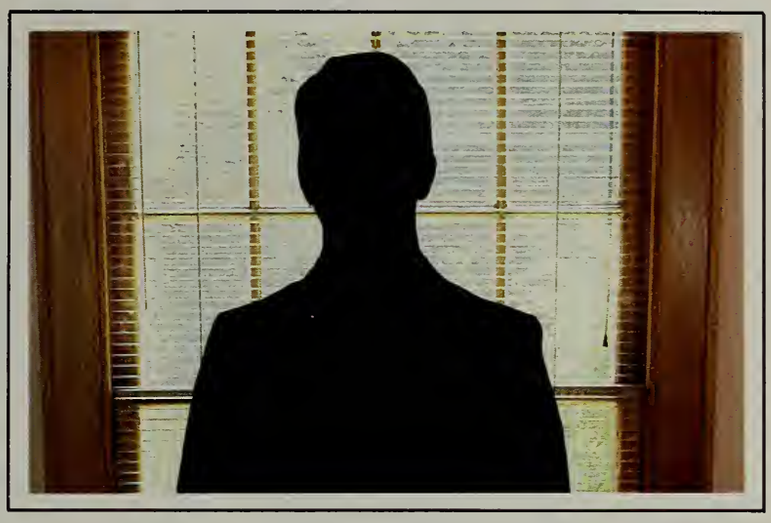
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FROM THE EDITOR



The Doctor as Patient

Sooner or later, the shoe is bound to be on the other foot. Crushed by stresses and pressures that have been accumulating since medical school, the doctor or a member of his/her family begins to show signs of depression. Soon, the practice . . . or the marriage . . . or the family unit . . . begins to buckle under the strain.

This issue of the Journal takes a look at the mental health of the medical family and how the pressures and strains which are inherent in the medical profession can affect your marriage, your children and you. The articles for this issue came from a recent seminar held by the Ohio Psychiatric Association — the colleagues who are frequently called upon to treat the unique problems of the medical family. If nothing else, this issue may help you see that your problems — and your family's problems — are not yours alone. Many of them are shared by your colleagues and *their* families. Whether or not you can personally surmount these problems, or depend on the help and support of a medical colleague, one thing is certain: The problems, whatever they may be, are treatable — if caught in time. But catching them is up to *you.*

Also in this issue, Marion pediatrician Albert May, MD, has written an exciting article which, for perhaps the first time in history, gives a pragmatic definition of the words "quality care." You won't want to miss it.

Our malpractice series continues with a look at the nationwide perspective, and President John E. Albers, MD, and Oscar Clarke, MD, Chairman of the Ohio Delegation to the AMA, report on the AMA's recent Annual Meeting in Chicago.

Geriatrics, sleep disorders and Ralph Nader on professional liability are some of the subjects you'll find in "Ohio Medi-Scene" this month, and Steubenville physician John Holman, MD, provides an interesting review of what appears to be a very worthwhile book.

Next month, we'll take a look at Preventive Medicine — a hot new topic that's stirred up a great deal of public interest in recent years. Are you practicing preventive medicine? Find out in the October Journal.

Karen S. Edwards

A WORD TO THE WHYS

WHY AMA?

The AMA actively works to represent your interests by fostering legislation that is beneficial both to the medical profession and the public. Each year the AMA makes thousands of contacts with members of congress and their staffs and frequently translates Association policies into model or draft legislation for governmental action. Active representation of organized medicine: it's one more good reason why you should be part of the AMA.

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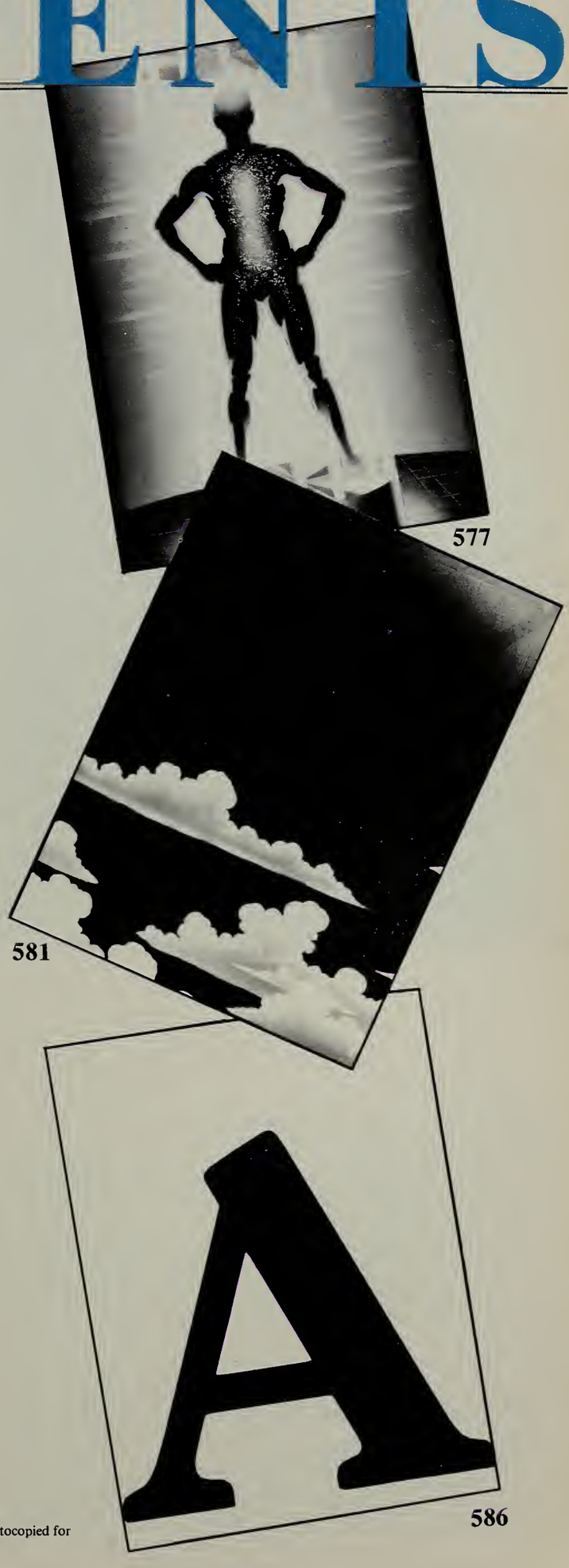
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JOURNAL COVER:

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PRECAUTIONS
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
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Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982.

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February, 1985

Physician Reimbursement

By John E. Albers, MD



We as physicians are concerned about the cost of medical care. We wish to be as frugal as possible in the treatment of our patients so that the cost of care is kept within reason without sacrificing quality; the quantity of medicine may be sacrificed. There are multiple factors which have led to the cost of medical care at the present time, not the least of which is the fact that our patients are living longer and requiring more sophisticated medications to keep them in a good state of health. An additional factor is the advancing technology which is now available to us. I do not believe that any patient or any physician would want to skimp on patient care because the medicine or the examination was too expensive. Although physician fees compromise a small part of the overall cost of medical care, it is the most appealing to the news media and to the public in general.

At the present time, the Health Care Financing Administration (HCFA) is studying several procedures relative to physician reimbursement and is attempting to relegate it to perhaps a fixed fee schedule. The Secretary of Health and Human Services has commissioned Harvard University to develop a system of physician reimbursement involving the Relative Value Scale which would be resource-based, meaning based on time, complexity, severity, training, and stress. The American Medical Association has a subcontract agreement with Harvard for developing and evaluating this program. Independently, the American College of Surgeons and the American College of Physicians are also studying a method of physician reimbursement involving the Relative Value Scale. Apparently the goal of these studies is to have more equality in physician reimbursement in reference to procedural and non-procedural physicians. There is inequality in fees in certain areas and in certain instances. I think that most physicians will agree that some services rendered are too expensive and that reimbursement for other services is inadequate. We have to be very concerned about this. The attitude of HCFA is: if a procedure is done more frequently and takes less time, the reimbursement should be less. On the surface this sounds logical, but becomes illogical when the procedure becomes more applicable to more patients and higher-risk patients and as knowledge and expertise increase the wider application of the procedure performed.

The Federal Trade Commission decided that third-party review systems were anti-competitive and should not be in existence. I believe our patients should have the access, and the right, to appeal charges which they believe are not in proportion to the services rendered, and I would like to see us resurrect the third-party review system. A group of physicians representing multi-specialties without self-interest are very capable of arriving at a fair decision for reimbursement. At the same time we should all, in our own conscience, look at our fees, consider the time, the complexity, the training necessary, the rapport established with the patient, and then we should each judge whether our reimbursement is commensurate with the services offered. Perhaps at times we value our services too highly and have become unrealistic in our charges. There are also many physicians who are not receiving fair reimbursement. There is an inequality that exists, and we as physicians, no matter what our specialty may be, should strive to correct this inequality. **OSMA**

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The Brains of Leaders

By Lawrence M. Weinberger, MD

I was enchanted with Dr. White's speculation on Comrade Gorbachaev's brain in the April, 1986 issue of The Journal. Dr. White's observations have considerable medical implications for the future, although Mr. Gorbachaev presently seems knowledgeable, astute, and thoroughly functional, and hardly seems on the verge of some stupid or impulsive act such as blowing up the world. Our intelligence agencies which might pursue this "hot tip" may possibly fumble it as they have so many other things, and thus nullify Dr. White's information. Still, such scientific insight is hard for the CIA to pursue, even though they have now been put on the alert.

On the other hand, what should the KGB's medical consultants make out of a 75-year-old president, who for some years has not gotten his facts straight, who makes frequently contradictory statements and egregious errors, who converts personal experiences into national policy, who repeatedly bases future policy on the "good old days" of his youth, and who, seemingly, forgets from day to day what he said before. Moreover, his memory span appears to be so short that he cannot make the simplest ceremonial statement without reading from prepared 3×5 cards; and his speeches, no matter how brief, are read from a TelePrompTer. Increasingly aging, this president has developed more and more paranoid trends about Communists here, and Communists there; he views himself besieged and threatened, and the United States imminently open to an invasion from Central America. These features are becoming more prominent, and the rhetoric which reflects these ideas more belligerent, strident, and vituperative, so that a sophisticated brain specialist, as for instance Dr. White, might easily imagine that these represent a possible senile dementia with aggressive and paranoid features.

Indeed, it seems to me that such a suspicion would be as compelling as those implications which follow the observation of Mr. Gorbachaev's port wine stain, and the possibility of an associated Sturge-Weber's Syndrome. But, if Mr. Gorbachaev has intracranial calcifications, they are not now causing apparent disturbances in function. Meanwhile, neurobiologists should worry about what is going on with our president's cognitive and affective processes.

However, the KGB is as handicapped as the CIA, since it is unlikely that either one could steal the respective CT scans. Alas, the anxious world will never know whether Mr. Gorbachaev's cerebral vessels are outlined by calcium, or our President's brain looks like a shrunken walnut. **OSMA**

Laurence M. Weinberger, MD, is retired from his practice in neurological surgery and now lives in Ventura, California.

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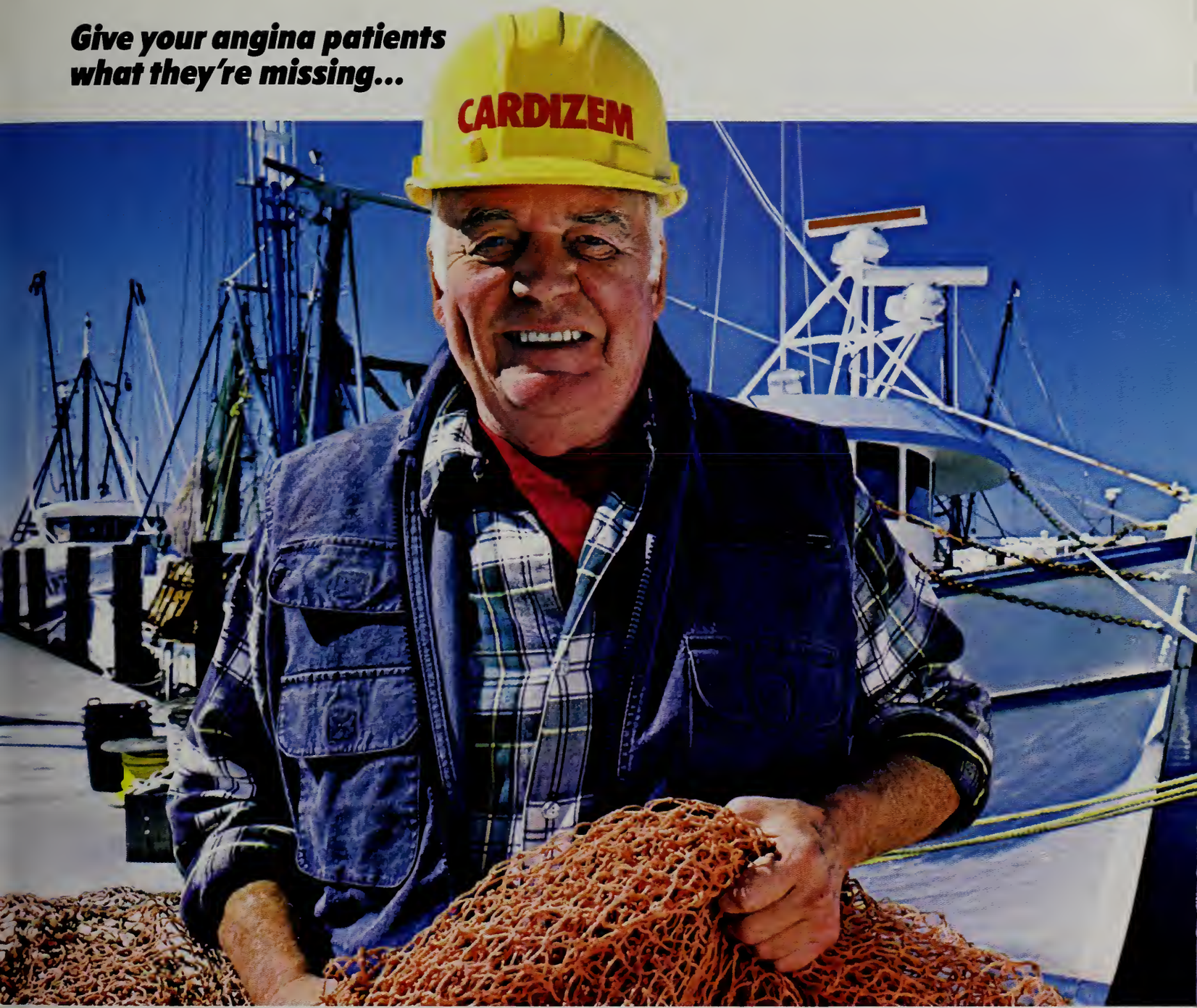
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CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 11/85*

See complete Professional Use Information before prescribing.

References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983; 106(6):1341-1347.* ***2.*** *Shapira W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984;24(Dec):150-159.* ***3.*** *Johnston DL, Lesowoy R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.*

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21st-century medicine

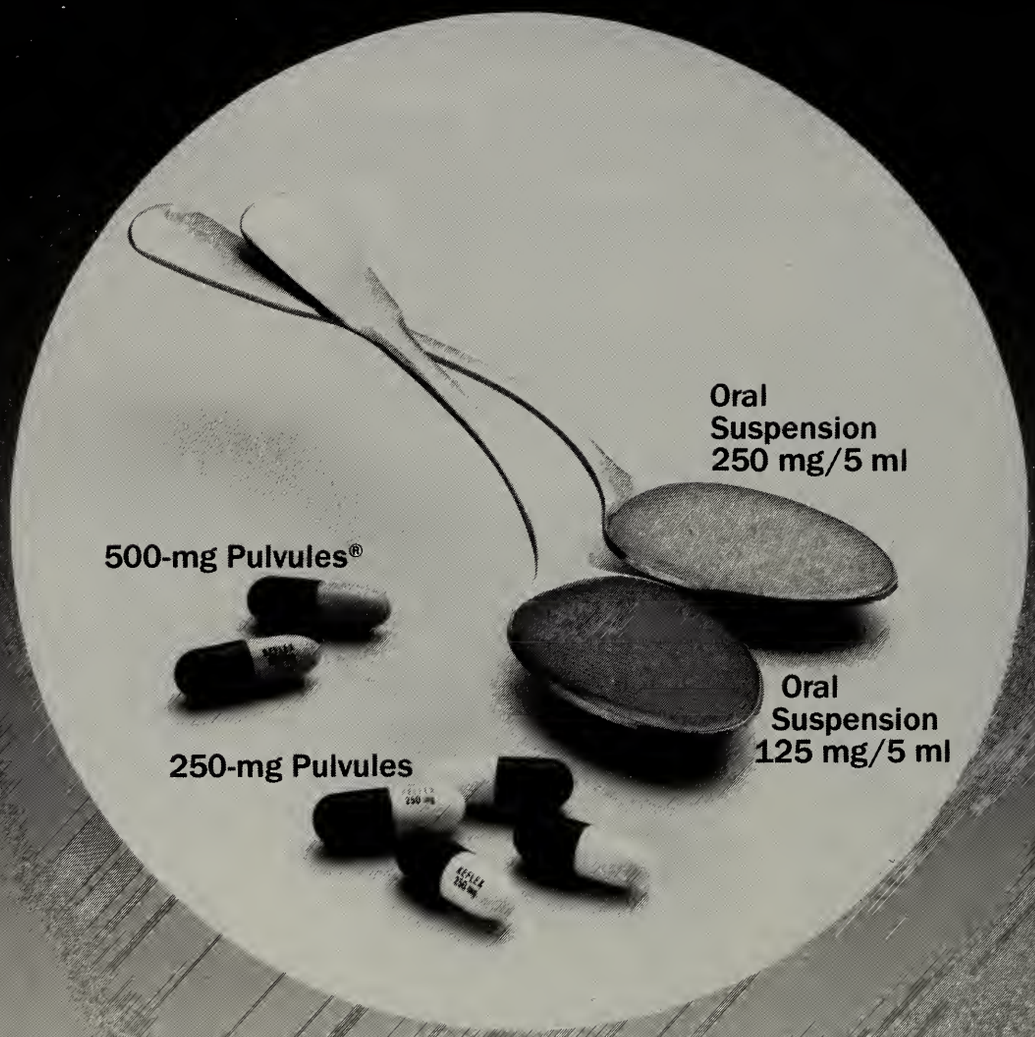


What is in store for the medical profession come the year 2000?

In the May/June 1986 issue of *Internist* magazine, published by the American Society of Internal Medicine, a variety of medical experts expressed the following views.

- "The truth is, the practice of medicine will never be the same again. Physicians will never have the same level of independence or the ability to work in an environment where there is neither a marketplace discipline nor government regulation such as we have had in the past." — Peter D. Fox, PhD, vice president, Lewin and Associates, Washington, DC
- "As we approach the year 2000, physicians will experience more intrusive review of their practices, and programs will require that standards be established to define the clinical circumstances under which services will be reimbursed." — Mark R. Chassin, MD, The Rand Corporation
- "There's a union in your (doctors) own future, whether or not you ever believed the day would come." — Sandord A. Marcus, MD, president of the Union of American Physicians and Dentists
- "It is fair to say that everything which can be properly done for members by a 'so-called' physicians' union can be done at least as well by other legitimate means of collective action, i.e., the medical society, the physicians' preferred provider organization or the medical staff . . ." — J. Paige Clousson, labor lawyer, president of Physician Support Services, Inc.
- "Medical education is being buffeted by the winds of change . . . We are going to need a cadre of clinical instructors who will provide our students with up-to-date and realistic instructions in clinical medicine." — Robert G. Petersdorf, MD, dean of medicine at the University of California and president of the Association of American Medical Colleges
- "While the breadth of health care in 2000 will undoubtedly be changed, it will not differ in magnitude as the prophets of doom envision . . . a reading of history lends credence to the generalization that the forces resisting change are nearly as powerful as those promoting it." — William C. Felch, MD, *Internist* editor
- "For over 20 years, health economists, sociologists, historians, demographers, philosophers, and politicians have been chanting requiem for the private practice of medicine in the United States. Yet, independent private practitioners, solo or in small groups, remain the dominant element in the delivery of medical care in this country and, in my judgement, will continue so for years to come. . . ." — Joseph F. Boyle, MD, ASIM executive vice president

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OHIO MEDI-SCENE

Ralph Nader on liability . . . a new dawn in sleep medicine . . . maintaining the elderly's independence . . .

Ralph Nader's thoughts on the liability crisis

Consumer advocate Ralph Nader had yet another societal bone to pick recently when he spoke about the current professional liability crisis at a presentation in Cincinnati co-sponsored by the Academy of Medicine of Cincinnati, the Cincinnati Bar Association and Grant Thorton, an accounting firm.

"This (the liability crisis) is an insurance-driven crisis, not a lawsuit-driven crisis," charged Nader, who, during his presentation, seemed intent on rattling the entire backbone of the U.S. insurance industry.

In Nader's opinion, the current liability crisis is a monumental facade created by insurance companies. The public and the media alike have had the wool pulled over their eyes, having been accosted by "lurid headlines" which painfully describe the malpractice crisis, Nader said.

Now, he added, there is a "factual counterattack which is informing the media that they were being largely manipulated by insurance companies."

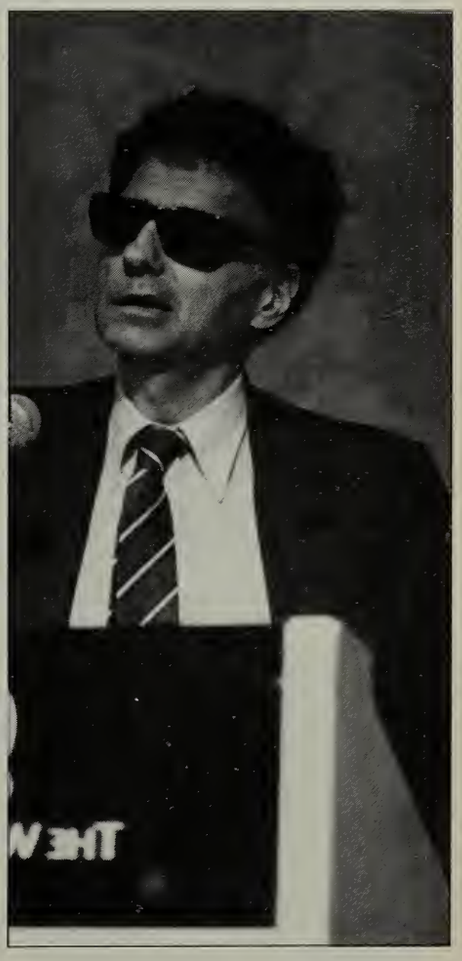
Contrary to the findings of a multitude of current surveys, most malpractice victims never recover a cent, he said. Likewise, Nader believes all the to-do about the outrageous number of million-dollar verdicts has been greatly exaggerated: "Let's don't denigrate this (justice) system by a few cases that have been overplayed by the press, the doctors, etc."

While Nader acknowledged that the courts are burdened by congestion and delay, he rejected the notion that the increased number of lawsuits is the result of lawyers toting briefcases full of frivolous, unwarranted suits into courtrooms.

In categorizing the justice system as "the fountainhead of human rights," Nader said the courtroom is "the only remaining forum in our country where a person can take on a major power" — be it a company, corporation, or, for that matter, the medical community, including hospitals and physicians.

"As long as it's (the lawsuit) not a shakedown or phony claim, we should applaud this response for justice." After all, he continued, the role of the justice system is more than just compensatory; it also serves to deter and to disclose negligence and irresponsibility in our fast-paced, highly industrious society.

So if it is not, according to Nader, a justice system gone askew or a society with a lawsuit fetish which have caused the recent "read 'em and weep" liability premium rates, what is it?



Nader claims the crux of the problem is an insurance industry which functions as a "financial cash cow" — worrying less about loss prevention than about investments.

OHIO MEDI-SCENE

Ralph Nader's thoughts . . . *continued*

"One spokesperson after another says they (the insurance companies) are losing money every year, but somehow they keep gaining money over a decade."

What we are witnessing, then, Nader says, is just the insurance industry spiraling into yet another proverbial cycle: premiums up, coverage down, and the rug being pulled out from under day-care centers, non-profit centers and the like.

"This is not a new era in insurance," he emphasized.

Nader likened the insurance industry to an "enclave" — a foreign territory — "one of the untold arcane segments of our society." People have "insurance blocks" the way they have "math blocks," he said.

Nader likened the insurance industry to an "enclave" — a foreign territory — and commented that people have "insurance blocks" the way they have "math blocks."

But, lately, "even the media is opening its eyes and seeing the light," Nader said, referring to a recent article in *Business Week* which labeled the *lawsuit* crisis a myth.

In reality, the increasing number of lawsuits is merely keeping pace with the increase in population, he claimed.

"Doctors are blaming the lawyers" for the high premiums they are paying, but perhaps the blame isn't being distributed appropriately, Nader said.

"Arbitrary and politically designed underwriting" is at the heart of the problem, he continued. Insurance companies should be relieving the burden of doctors, he added.

According to Nader, the crisis at hand is a solvable one, but he sees attempts to alleviate the problem by establishing limits on pain and suffering settlements as "restricting patients' rights." This type of tort reform only succeeds in penalizing those who are already the most vulnerable people in the country, he said.

While Nader acknowledged that there is room for some reform in the court system — a need to censure the lawyer *who is* abusive and to trim congestion and delay — he also suggested that there is ample room for skepticism about the mechanics of the insurance industry. — *Deborah Athy*

A new dawn in sleep medicine

"A scientist alone is the sound of one hand clapping," Thomas Roth, PhD, of the Henry Ford Hospital in Detroit told some 800 participants at the first annual meeting of the Association of Professional Sleep Societies, held June 15-20 in Columbus. However, by uniting their efforts, researchers in sleep disorders can take major strides to "pull back the curtain of the night," and to uncover the many mysteries that still surround that period when mind and body are "at rest."

The theme of the conference was "A New Dawn in Sleep Medicine," and its purpose was to unite the members of four different sleep societies — The Association of Professional Sleep Societies, the Sleep Research Society, the Association of Sleep Disorders Centers, and the Association of Polysomnographic Technologists — into a single federation.

While all four of these organizations now focus on the clinical specialty of sleep disorders medicine, the area is still in its infancy, according to program coordinator Helmut S. Schmidt, MD, founder and director of the Ohio State University's Sleep Evaluations Center. Thus a concerted effort must be made to unite these independent professionals in their pursuit of a better understanding of sleep and sleep disorders.

"Man at the turn of the century knew nothing about what happened during the night," William Dement, MD, said in discussing one of 82 clinical papers selected for presentation at the conference. "At first, REM sleep was considered very controversial. Many didn't believe it existed."

Freud and his psycho-analytical approach to dreams and other mental phenomena dominated the early days of sleep research, Dr. Dement continued.

But, today, sleep research impacts on nearly every aspect of medicine, said Henry Nasrallah, MD, chairman of the Department of Psychiatry at the Ohio State University.

"Sleep medicine is one of the most exciting new disciplines in medicine," said Dr. Nasrallah. "It cuts across numerous disciplines — cardiology, urology, ENT, pharmacology — and it has an impact both clinically and in research," he said.

Manuel Tzagournis, MD, dean of the College of Medicine at OSU, pointed out that the sleep lab developed by Dr. Schmidt in 1977 (the sixth such center in the United States) is providing a new way to study the link between diabetes and impotence. "We now have a way to determine both the psychological and the physiological aspects," he said.

The study of sleep disorders is vital not only to medicine, but to all of society, as problems from lack of sleep can lead to loss of work productivity, alcohol abuse . . .

The study of sleep disorders is "vital not only to medicine, but to all of society," Edward Jennings, PhD, president of the Ohio State University, told the participants, who included physicians, social workers, scientists, researchers and other professionals in the health science field. Health problems caused by sleep disorders lead to a loss of productivity in the workplace and may also be linked to Alzheimers, drugs and alcohol abuse, he said.

Perhaps of greatest significance are the millions



OHIO MEDI-SCENE

New dawn for sleep disorders . . . *continued*

of people who are drowsy on the highway due to an inadequate night's sleep. "The goal of increasing public awareness about this problem cannot be overplayed," said Woodrow A. Myers, Jr., MD, state health commissioner for the Indiana State Board of Health and the keynote speaker at opening ceremonies. "Many deaths and disabilities result from traffic accidents caused by falling asleep at the wheel."

Today's health commissioners, said Dr. Myers, are dealing with everything from AIDS to organ transplants. "Can we overload the public health system with yet another challenge?" he asked. Yet the need to continue research in this area is of "clinical benefit to all of us," he said.

"Underneath our feet, two billion individuals are trying to sleep," said Dr. Myers. Perhaps in uncovering the mysteries of nighttime rest, the consequences of that final sleep might be better understood, he added. — *Susan Porter*

Correction

S. Marcus Wigser, MD, the new president-elect of the Academy of Medicine of Cincinnati, was incorrectly identified in the June *Journal* as a neurosurgeon from Providence Hospital. Dr. Wigser is, in fact, a neurosurgeon at the Mayfield Neurological Institute, and Chairman of the Department of Neurosurgery at the Jewish Hospital in Cincinnati.

Maintaining your elderly patients' independence

When it comes to taking care of your elderly patients, there are three goals to keep in mind, says Ronald D. T. Cape, MD, Chairman of the Division of Geriatric Medicine at the University of Western Ontario and Parkwood Hospital in Canada. Cape was the keynote speaker at the geriatrics/gerontology section meeting held during the OSMA's Annual Meeting.

According to Dr. Cape, the goals of primary medical care for the elderly are as follows:

1.) To maintain the independence of these patients by keeping them in their own homes as long as possible.

2.) To minimize disability and disease in old age.

3.) To encourage and support families caring for the elderly.

Of course, understanding the facts about disease and disability in old age is essential if these goals are to be realized, says Dr. Cape.

"Throughout our lives, from a biological standpoint, we are constantly changing," he points out, stressing that the optimum state of maturity is reached by most people in their early twenties.

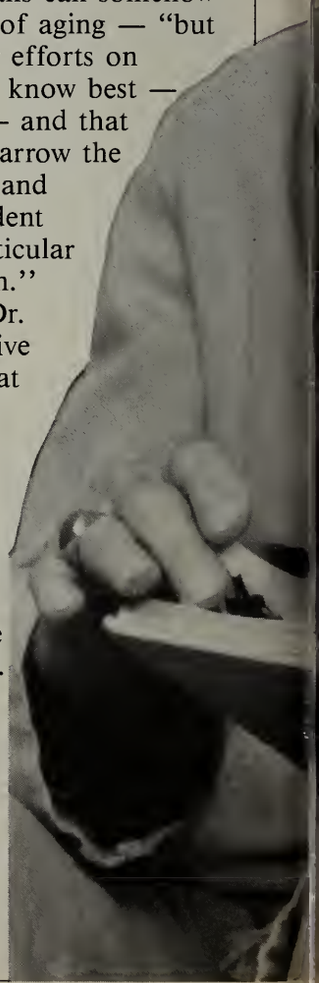
"Then, all of our bodily functions have their optimum capacity and greatest reserve of function. Thereafter, the decremental effect of time begins to exert its influence on us," he warns.

Dr. Cape believes that it is the physician's job to have a broad understanding and knowledge of biosenescence, as its affects the human body — knowledge which "will enable us to distinguish aging from disease," he says. Not that he hopes physicians can somehow alter the process of aging — "but we can focus our efforts on tackling what we know best — namely disease — and that may help us to narrow the morbidity band and increase independent living in this particular at-risk population."

According to Dr. Cape, there are five practical steps that can be taken to improve the prospects of our elderly population maintaining their independence — particularly those aged 85 and over. They are:

1.) Education

"Education is for the patient," says Dr. Cape. "The elderly still



(Photo courtesy of Upjohn Company)

have a low opinion of what can be expected in old age. They anticipate disabilities and problems, and when these arise, they accept them and do nothing about them.''

The elderly need to be convinced that positive steps can be taken to ease or relieve pain or disability, he says, and their expectations of physical fitness in the latter stages of life must be raised.

2.) The role of the primary care physician

"For elderly subjects, regular contact and discussion with the primary care physician can be of great benefit,'' says Dr. Cape.

"The well-trained primary care physician will then be in a position to intervene before disabilities get out of hand,'' emphasizes Dr. Cape.

A missed appointment will alert the primary care physician to possible trouble and the need for a home visit to investigate the situation — but it is that fifteen-minute discussion and contact with the patient in the office that will usually give the physician the clue as to how things are going.

3.) Families

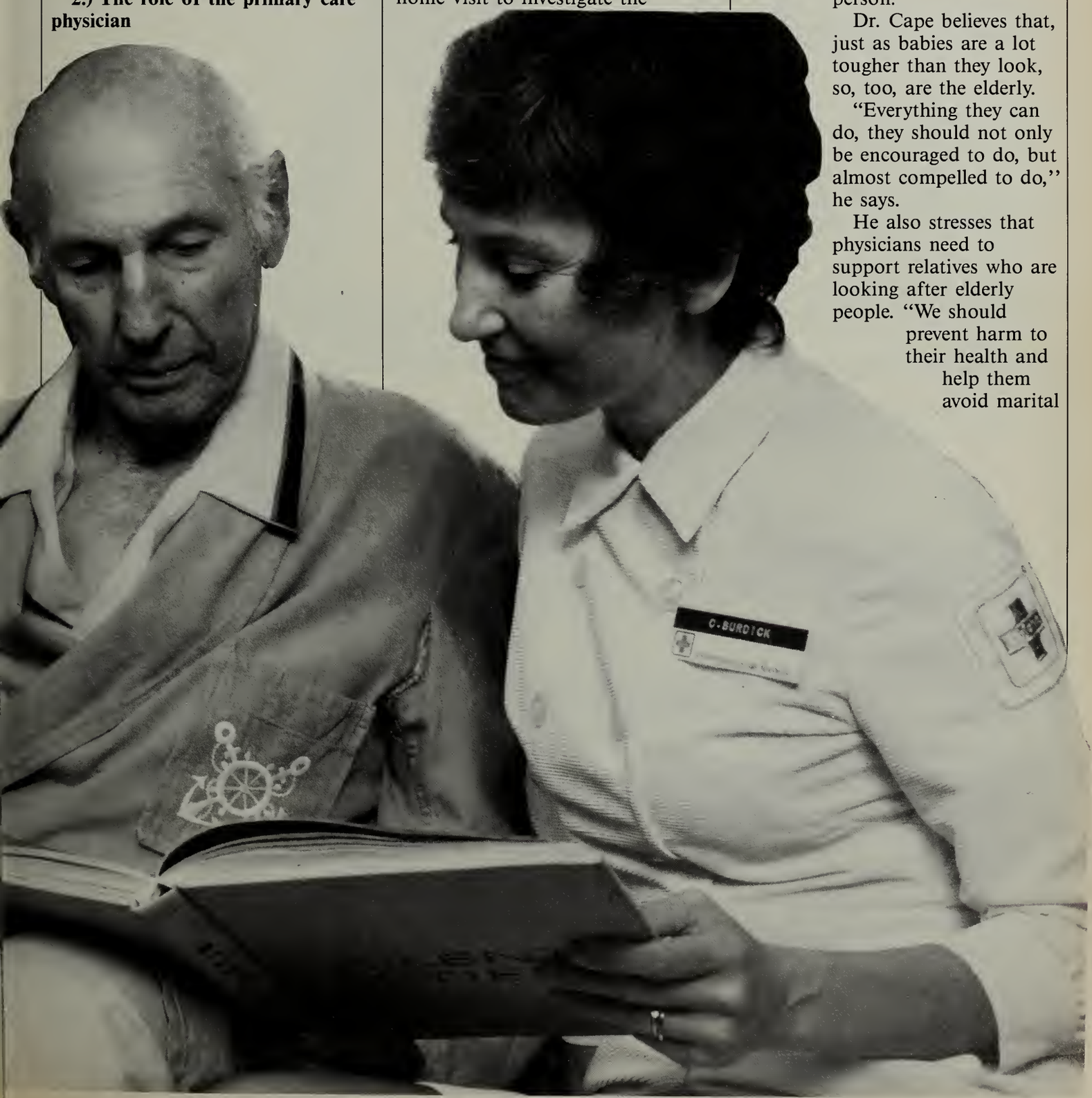
Like the patients themselves, families need education and encouragement, says Dr. Cape.

"They usually err in taking too soft an approach, and tend to spoil or mollycoddle the elderly person.''

Dr. Cape believes that, just as babies are a lot tougher than they look, so, too, are the elderly.

"Everything they can do, they should not only be encouraged to do, but almost compelled to do,'' he says.

He also stresses that physicians need to support relatives who are looking after elderly people. "We should prevent harm to their health and help them avoid marital



OHIO MEDI-SCENE

Maintaining the elderly's independence . . . *continued*

and other family problems arising as a result of the need to provide care for the elderly person."

4.) Support services

Because support services can be less costly than the institutionalization of an individual — and allow the individual to maintain his or her independence — Dr. Cape believes that these types of programs — especially the homemaking type — should be developed to their fullest potential.

"In the American situation, it would seem to me that local, regional arrangements should be planned to provide such services and these could then be subsidized by state or federal provision," he says.

5.) Evaluation and rehabilitation teams

"Many disabilities begin as acute problems treated in general hospitals," says Dr. Cape. The smooth transition from general hospital to temporary accommodation to reactivation and rehabilitation is a necessary step in preserving the independence of the elderly, he adds. "Physicians (should) focus on the needs and problems of the individual patient, and use institutions intelligently."

— *Karen S. Edwards*

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The 5 A's of Health Care System Quality:

Suggested Criteria and Methodology For a Consensus-Derived Systemic Definition of Quality in Health Care

By Albert N. May, MD

Editor's note: *As a member of the Health Care Cost Panel of the Interprofessional Commission, Albert N. May, MD, first voiced an idea which is unique to health care. His idea is that "quality care" — a phrase that has received much attention lately in the face of health care cost cuts and the professional liability crisis — is, in fact, a tangible word, capable of being removed from the philosophical realm and defined pragmatically — the same way*

continued on page 648

Quality!

What is quality?

In its simplest terms, quality may be defined as getting the biggest bang for the buck. This probably is as true for the health care delivery system as for other commodities.

A fuller definition of quality in health care has always been both troublesome and elusive — in fact, many claim that defining quality within the context of the health care system is impossible. It may be analogous to the situation of a mid-westerner on his first visit to the Guggenheim Museum in New York City, who, upon seeing a painting for which his prior experience had not prepared him, says, "I don't know much about art, but I know what I like when I see it — and I know what I don't like."

Quality in health care, while hard to define and put into words, is something most people intuitively feel they recognize when they see it, or, conversely, appreciate its absence.

Maybe the difficulty has been due to a preoccupation with

OUTCOMES in determining quality. Such a preoccupation tends to focus highly on specialized areas. Thus, an epidemiologist may look at the percentage of susceptibles who are/are not immunized against vaccine-preventable diseases as an index of systemic health care quality. A pediatrician may look at perinatal mortality rates; a pathologist at autopsy percentages; a hospital administrator at occupancy rates or drug overstay; the patient at out-of-pocket expenses for health care; the employer at lost-time on the job; HMO management at after-duty hours, emergency room utilization rates, etc., etc., etc.

An alternative method at evaluating health care system quality might well entail examination of the **SYSTEM STRUCTURE** and **PROCESS** from the viewpoint of how these meet the identified needs of the **PROVIDER, PAYOR** and **CONSUMER.** The **PROVIDER** would include, of course, institutional and individual providers (hospitals, physicians and physician groups, pharmaceutical houses, durable medical equipment distributors, nursing homes, home health care services, hospice services, to name a few). The **PAYOR** includes federal, state and locally supported health insurance programs, traditional indemnity private health insurance programs, alternative health insurance programs, including HMOs, PPOs, as well as the otherwise uninsured consumer himself. The **CONSUMER** includes those segments of the population with and without insurance coverage; it includes the entire spectrum of the population from the unborn to the aged.

Quality in health care is something most people intuitively feel they can recognize when they see it, or, conversely, appreciate its absence.

While the **CONSUMER, PAYOR** and **PROVIDER** each represents differing and sometimes conflicting perspectives on the health care delivery system, each can be focused on agreed-upon criteria encompassing quality.

The five criteria herein offered are meant to begin this process of quality definition. They are certainly not meant to be all-inclusive, and they may not be the best choices. They can be used to be the fodder for discussion and debate, making the beginning of a process by which workable criteria for defining quality in health care systems might be achieved through consensus of those constituencies serving and being served by the health care delivery system.

The A's represent criteria which appear to be associated with health care delivery systems whose services and products are marked by quality; they are:

ACCESSIBILITY;
ACCOUNTABILITY;
AFFABILITY;
AFFORDABILITY;
AVAILABILITY.

By **AVAILABILITY,** we mean a full range of integrated health care services running the spectrum from preventive health care, including anticipatory guidance for consumers throughout all of life's ages, through the entire range of remedial intervention (including acute and chronic medical/surgical services on both an in-patient and out-patient basis), along with home health services and long-term intermediate and skilled nursing services to hospice

services. This criterion of availability of health care services, of course, has a different connotation when scrutinized from the varying perspectives of the provider, payor and consumer. The provider may be concerned about availability of capital to establish such a system, and whether the system can be utilized to the degree necessary to amortize initial investment and provide a reasonable profit; the payor can be expected to be concerned that such a system by its own weight will be over-utilized in order to justify the capital investment of its development; and the consumer may well feel that whatever his need, it should be met maximally whenever it arises and wherever he happens to be. Certainly differing viewpoints, but ones in which reasonable dialogue may well be able to forge consensus parameters and objectives by which this criterion of quality in the health care delivery system can be described and measured.

A related criterion to availability is **ACCESSIBILITY,** by which we mean generically that needed services by the above-described system are so situated as to be accessible to consumers. Again, the perspectives of the three constituencies of the health care system are brought into focus for the purpose of developing objectives and parameters which describe and measure this particular criterion. The provider may be willing to develop satellites and programs providing services to consumers; on the other hand, where geographic obstacles to accessibility may exist, an integrated approach in developing specialized transportation mechanisms to overcome those obstacles may be an appropriate strategy. The payor's view may encourage the fiscal support of programs that increase accessibility to services without increasing capital costs. The consumer's strong desire for increased accessibility to health care services is probably one of the most highly promoted aspects of consumer advocacy organizations at the present time. Here again, we feel that the task of establishing suitable parameters and objectives which describe and measure this particular criterion is a function of rational dialogue among spokespersons for the three constituencies named.

Affordability, as a suggested criterion in the process of defining and measuring quality, is a relative newcomer when applied to health care systems.

AFFORDABILITY, as a suggested criterion in the process of defining and measuring quality, is a relative newcomer when applied to health care systems. It has been brought more sharply into focus by recent government initiatives in the area of prospective payment for health care services, controlling capital costs, promotion of mandatory second opinions and pre-admission certification as a means to control access to high-cost sites of health care services, development of utilization review and quality insurance methodologies to control provider over-utilization, and by increasing consumer financial participation in the reimbursement of health care costs. All of these mechanisms, as well as others, suggest that society's spokespersons consider the inflationary health care cost spiral to be a significant flaw in the health care delivery system.

A close look at the difficulties experienced by many hospitals which have in the past been over-utilized, over-developed, over-expanded, and, in some instances, over-priced, with resulting difficulties in financing both debt and day-to-day operations sharply brings the criterion of affordability into focus from the viewpoint of the provider. Much can be said along the same lines from the viewpoint of the payor, who increasingly is rebelling at expending scarce fiscal resources for the aid and nourishment of some of these fatally diseased organizations. The consumer's viewpoint of affordability is apt to be couched in terms relating to out-of-pocket expense for specific services and ways and means to reduce this expenditure to a minimum while safeguarding access to these services. Once again, there is an interesting melange of perspectives which must be heard and debated in order to arrive at consensus parameters and objectives which describe and measure this criterion.

Another criterion for health care system quality is **ACCOUNTABILITY.** By this we mean that the various elements of the health care system are accountable for the appropriateness of all services rendered; in addition, the criterion is broad enough to cover those aspects of credentialing, accreditation and certification which act as generic hallmarks of baseline quality by which consumers may judge both institutional and individual providers and upon which payors

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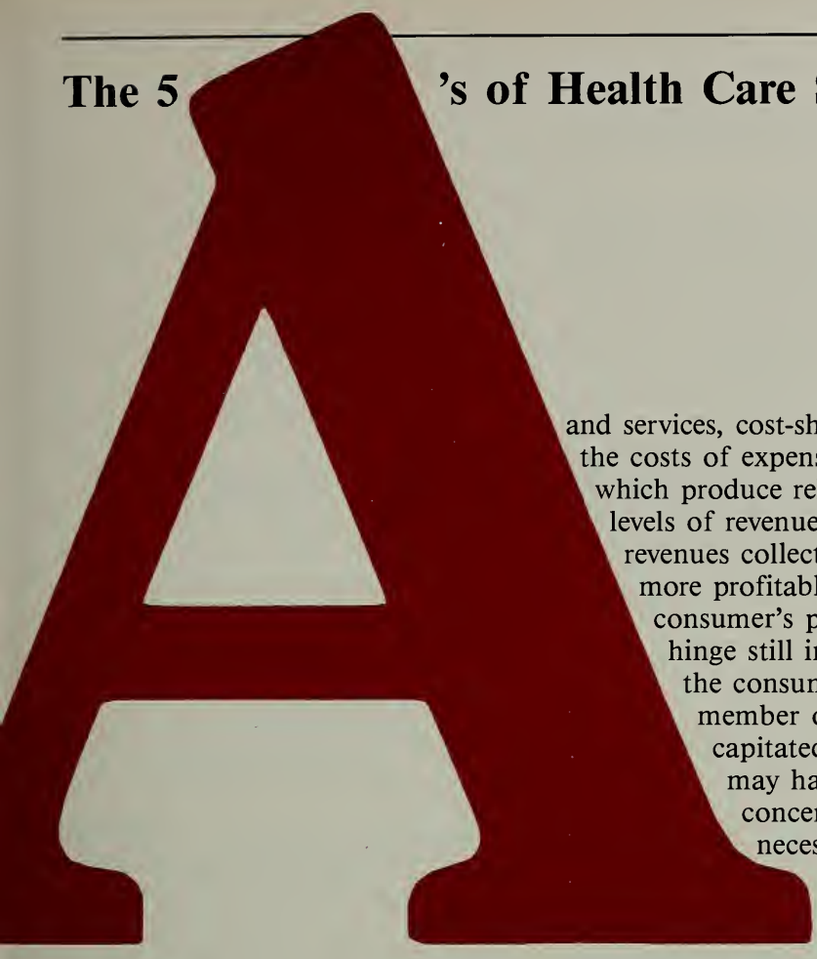


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The 5 A's of Health Care System Quality . . . *continued*



and services, cost-shifting whereby the costs of expensive services which produce relatively low levels of revenue are borne by revenues collected from other more profitable services. The consumer's perspective may hinge still in other areas: the consumer who is a member of a pre-paid capitated medical plan may have legitimate concerns that necessary services for his needs may be under-utilized.

These, then, represent a few of the intrinsic conflicts which may pertain to a meaningful dialogue among the three perspectives in an attempt, once again, to achieve a consensus on parameters and objectives that accurately describe and measure the criterion of accountability.

The final criterion for a quality health care system which we offer is that of **AFFABILITY,** by which we mean that the system ideally should be consumer-friendly and that all aspects of the system provide services in a caring and truly personal manner. The parameters by which this criterion could be measured are indeed subjective, but, in the final analysis, may be developed with the least conflict and heat among the perspectives expressed by the provider, the payor and the consumer.

These, then, are the 5 A's of health care system quality which we offer to you to begin the process of discussion, dialogue and debate in the hope of at least initiating the process by which health care quality can, at some time in the future, be more accurately described and measured by consensus.

Health care system quality defined through this process is a pragmatic concept which has the possibility of development, evolution and change in response to a variety of environmental, societal, professional and governmental factors, constraints and incentives. Such a concept may be more useful in the planning, implementation and evaluation of health care delivery systems than a concept of health care system quality idealized as an immutable, indefinable abstraction. **OSMA**

Albert N. May, MD, a pediatrician, is a trustee for the American Group Practice Association, vice president of the Smith Clinic in Marion, and a consultant to the Federation of American Hospitals Task Force on Defining Quality in Health Care Systems. In addition, Dr. May serves as the OSMA representative to the Interprofessional Commission on Education and Practice, and sits on their Health Care Costs Panel.

Health care system quality is a pragmatic concept which has the possibility of development, evolution and change . . .

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The Physician as Patient

By Susan Porter

By and large, doctors make pretty poor patients. When they aren't trying to duck out of appointments or skip suggested therapies, they are demanding explanations for every procedure or ordering staff members around the examining room. And when they do finally have to admit there's a problem, they tend to get well too quickly — a phenomenon coined "flight into health" — without really allowing themselves the time and care they need to make a full and complete recovery.

Perhaps nowhere is it more true than in the area of mental illness, where physicians — like most people — are hesitant to admit that they may have some personal problems. These problems range from mild bouts with anxiety and depression, to serious impairment due to drug and alcohol abuse.

And while a physician may be the last to seek help for any of these, "the public demands that physicians be accountable," says George T. Harding IV, MD, medical director at Harding Hospital in Columbus, who addressed fellow psychiatrists at a special seminar on "Psychiatry and the Treatment of the Medical Family" last June.

For the benefit of physician and patient alike, it is essential that doctors stay in top mental and physical condition. Yet the demands placed on the physician are tremendous, according to Dr. Harding, so that often the physician's health care needs are the last to get attention. "Physicians face many extra pressures," he says, "overscheduling, the pressure to stay current, community expectations and so on."

Even those who are able to cope with the many stresses and strains of a 60-hour-a-week-plus practice eventually wear down. Depression is the most common form of mental illness seen in physician patients, says Dr. Harding.

Yet as early as college and medical school days, physicians learn to become masters at denying or suppressing their feelings. "Fatigue, responsibility, fear of failure — these are common feelings for medical students and residents," says Dr. Harding. Physicians-to-be are taught to disregard their personal feelings as they struggle to digest the contents of mountains of textbooks and to put the lives and welfare of their patients before their own personal feelings and needs.

"Add to this the phone calls you have to make to the family of a dead patient, or the disclosure of a fatal diagnosis to a patient," says Dr. Harding, "and it seems we are always carrying tragedy to others. As physicians, we learn to suppress our grief daily."

All of this adds up over the years, until "finally, in the middle years, a physician may be overwhelmed by a flood of despair," he adds. Yet denial continues to be a common response and the despair may be suppressed with the help of drugs and alcohol. Eventually, the impairment may lead to a loss of competency, legal ramifications and family problems.

An estimated one out of 10 physicians is "impaired," according to AMA statistics, points out Dr. Harding, compromising the care of more than 100 million patient visits a year. "If you consider that there are 300,000 physicians in the U.S., you begin to realize we are dealing with a large problem," he says.

The AMA defines an impaired physician as "one who is unable to practice medicine with reasonable skill and safety because of physical or mental illness, including deterioration through the aging process or lack of motor skills or excessive use or abuse of drugs including alcohol," says Dr. Harding. While there are many levels of impairment, alcohol abuse

As early as college or medical school days, physicians learn to become masters at denying or suppressing their feelings.

is by far the biggest culprit — some 7% to 8% of all physicians are or will become alcoholics, Dr. Harding continues.

Is the problem greater among physicians than it is in the general public? "Probably so," says Dr. Harding. "Males are four times more likely than females to become alcoholics and college graduates are more likely than non-college graduates. Today, the medical profession remains predominantly male, and we are all college graduates."

Add to this the physician's high income and easy accessibility to prescription drugs, and the physician is in a high-risk group equal to no other. Another sign of increased vulnerability: doctors and health care workers are twice as likely to commit suicide as the general population, says Dr. Harding.

Part of the problem lies in the personality structure of the "good" physician. While an innate ability to make quick and sure decisions is mandatory in the medical profession — and is continually fostered throughout the physician's education and training — this can also lead to compulsiveness, obsessiveness, and feelings of inadequacy and guilt, particularly if a procedure does not work as expected. Physicians also tend to suffer from "excessiveness, a lack of pleasure in their lives and strong feelings of responsibility — all of which lend themselves towards depression," says Dr. Harding.

Roy Menninger, MD, president of the Menninger Foundation, who also addressed the conference, says most physicians are "hyperconscientious — have an exaggerated sense of responsibility." Yet, at the same time, they have a limited capacity for sharing their burden with others by expressing their feelings and concerns.

"Physicians tend to be altruistic, voyeuristic — to identify with other strong figures such as mentors and heroes," says William M. Klykylo, MD, associate director for training in the department of psychiatry and psychology at the Children's Hospital Medical Center in Cincinnati. Always striving for perfectionism, the physician deals in an imperfect world where death ultimately takes the upper hand.

What results, says Dr. Menninger, is a "chronic sense of inadequacy — a gap between expectation and achievement. High expectations lead to vulnerability and feelings of guilt and depression. Ultimately, every physician feels defeated."

Yet the typical response is to work even harder and longer and to maintain an image of self-reliance, independence and control. The physicians may become dedicated to his or her patients to the detriment of family and personal life, until finally nothing is left but a facade.

"Each of us knows a colleague who is showing signs of impairment," says Dr. Harding. "Yet this is a subject most of us prefer not to think about. It is a deeply personal subject."

Primary disorders may be difficult to recognize and treat, says Dr. Harding, because denial exists not only by the patient but also by his/her family, colleagues and even patients. Often an unspoken cover-up exists because "we tend to want to protect physicians from any sort of criticisms," says Dr. Harding.

But it is a problem that must be addressed, he says. "Number one, for the safety of our patients. Number two, to maintain the public's trust in us. And number three, because we need to learn to care for each other — because we understand the unique stresses of physicians and their family members.

Signs that a physician colleague may be suffering from an impairment are: mood or personality change, loss of reliability, increase in sick days or accidents, patient complaints, indecisiveness, slowness, isolation (both professional and socially), marital problems, problems with children, frequent intoxication, persistent overwork and fatigue, a history of moves and new jobs, and legal problems.

Physicians can anonymously report their suspicions that a physician may be impaired to the Ohio State Medical Association's Physicians Effectiveness Program (PEP), says Dr. Harding. The program is designed to help physicians face their impairment by confronting them with the problem. Physicians in the program act as advocates for their impaired colleagues, helping them to seek and select the appropriate treatment. The patient's family may also be involved in the process. "The bags are often packed and ready to go," says Dr. Harding.

Controversy still exists in the medical profession over which problem comes first — the

Physicians need to learn to become better patients, and to express their fears and frustrations more regularly and easily.

depression or the alcoholism, Dr. Harding admits. "I suspect both are true," he adds. "I think we need to look at the problem both ways."

Regardless, physicians need to learn to become better patients, and to express their fears and frustrations — along with their joys and successes — more regularly and easily, the psychiatrists agree.

What's more, says Dr. Harding, they need to look out for one another in a way that will eventually prove helpful to the impaired physician and his/her patients — rather than inadvertently helping a colleague to cover up a problem by ignoring its existence. Even the potential threat of liability should not keep a physician from being his brother's keeper, he adds.

"Many problems can be observed early," says Dr. Harding. "Don't wait for absolute proof. There is no 100% certainty. Alcoholism and drug abuse do not go into spontaneous remission. *You* must identify them." **OSMA**

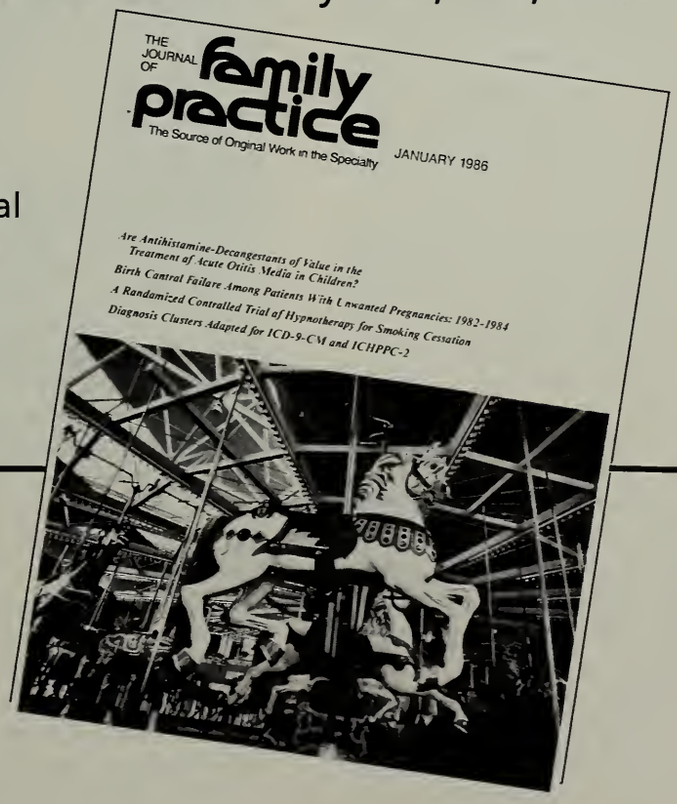
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The Physician Parent: Like Doctor/Like Child

By Susan Porter

Most kids *like* being a doctor's child — at least according to a unique study which appeared last year in the *Journal of the Maine Medical Association.* The article — one of a very few studies done on this topic — was based on a questionnaire given to the children of a group of physicians in that state. When all of the results were tabulated, the survey showed that 97% of these children felt positive about having a physician parent, and 70% felt it helped in their school and social lives.

Some 44% of the youngsters responding did admit that too many family activities had to be postponed or canceled because of their parent's work. However, 99% said they didn't really mind, and 73% said they wanted to know more about their physician parent's occupation.

So, having a physician parent is good for a child's mental health?

Not necessarily, according to Roy Menninger, MD, president of the Menninger Foundation and one of several physicians to address those attending a special seminar on "Psychiatry and the Treatment of the Medical Family," sponsored recently by the Ohio Psychiatric Association.

While children of physicians may *say* they are proud, happy and perfectly content to have a parent in the medical profession — and many of them may even aspire to becoming physicians themselves — it's what they don't say that could indicate that problems lurk beneath their smiling and composed demeanors.

"When asked, kids will give appropriate and beautiful examples of what it's like being the kid of a physician," Dr. Menninger says. What they frequently cannot admit, however, is a chronic sense of neglect, an emptiness that results from having a mom too busy to drive in a car pool or a dad unavailable for camp-outs or T-ball practice.

Like their physician parents, the children of physicians may appear to be diligent, self-sacrificing and loyal — to their own detriment. Their overly optimistic attitudes may be one of many signs that they are not giving enough priority and attention to their own personal needs.

"These kids may grow up with a sense of neglect, yet at the same time they have a strong sense of loyalty," Dr. Menninger explains. Their parent is involved in a highly visible and important occupation — that of saving lives — so it's hard to complain when that parent isn't available for an impromptu game of basketball or can't take off for an afternoon trip to the zoo.

Physician parents also tend to be perfectionists, says William M. Klykylo, MD, associate director for training in the Department of Psychiatry and Psychology at Children's Hospital Medical Center in Cincinnati, who also spoke at the conference. Because they expect so much of themselves, they also expect a lot from their children, he says, so that "a child may feel it is impossible to meet the parent's expectations." Thus children of physicians may work constantly to get the approval of their physician parents — in school, athletic and extracurricular activities — yet they maintain the feeling that no matter what they do, it isn't enough — much like physicians frequently feel they have let down



their patients and could have done more for them.

Like most parents, physician parents inadvertently pass on to their children their own weaknesses and shortcomings — along with their talents and strengths. "Kids pick up on their parents' unconscious cues and may feel anxious and unassured," Dr. Klykylo says. For instance, the child of a physician who has recently lost a patient may also feel defeated and may even feel to blame for the parent's unhappiness. Just as many physicians have an exaggerated sense of responsibility, their children, too, may feel guilty for situations over which they have no control.

Among other common personality traits a physician parent may pass along to a child are compulsiveness, a restricted ability to express warm and tender feelings, and indecisiveness, says Dr. Klykylo. Younger children are particularly susceptible to internalizing their parents' anxieties and conflicts.

"Parents of younger children are usually younger themselves," Dr. Klykylo points out. "They may still be in training or just starting out in practice. This is typically a hard time (for the parent), full of new responsibilities and uncertainties."

In addition, physicians "undergo a constant stream of experiences that overwhelm their own psyches," he continues. "Yet we have to be strong and confident — we can't let people know how worried or stupid we are."

Thus the child also learns to be silent — to develop a facade of complacency and control and to keep emotions under constant check. This behavior may be further reinforced by comments like, "You have to be a big boy/girl because mommy/daddy is busy." Some children may even stand in awe of the physician parent and thus appear passive and withdrawn. Beneath the surface, however, strong feelings of insecurity, anxiety, and even anger may stew.

Guilt and its Effects

Because they feel guilty for not having time to spend with their children, physician parents may

Some may realize their children have problems, yet the physician parent may find it difficult to ask for help because they are afraid to "bother" a colleague, or afraid to admit they can't cure their own child.

further placate their children with material possessions, says Michael Maloney, MD, another speaker at the seminar and director of the Division of Child Psychiatry and Psychology at Children's Hospital Medical Center in Cincinnati. Eventually, however, some children will rebel — they will throw aside their parent's even-tempered attitude and comfortable lifestyle and become a kind of "community rebel" — frequently getting into trouble with drugs, reckless driving and promiscuity.

It is at this point that some may realize their children have problems — yet the physician parent may find it difficult to ask for help, particularly from a psychiatrist — another physician. Some, says Dr. Klykylo, may fear they are "bothering" a colleague; others are afraid to admit that they, themselves, are unable to "cure" or help their own child. "It's a carry-over from medical school," says Dr. Klykylo. "If you don't know what's going on, you feel dumb so you don't ask." And finally, there may be a great deal of shame and embarrassment on the part of the physician parent who frequently feels to blame for the child's problems.

For all of these reasons, "physicians and their families often receive less than adequate psychiatric attention," says Dr. Maloney. And when their children do end up in therapy, physician parents are frequently uncooperative. They tend to "intellectualize and question the therapy," says Dr. Maloney, asking for concrete explanations for diagnostic procedures and problems not always easily explainable. "Often they don't know or understand psychiatry — yet we assume that they do" because they are physicians, says Dr. Maloney.

They may react by refusing to participate in family therapy sessions, blaming a busy work load or emergency situations for their absences. They may also blame the therapist for the lack of simple and direct solutions to their children's problems, question the merits of psychiatry, and pull the child out of treatment if immediate results are not seen.

On the other hand, some physicians expect special treatment — they may ask for unusual appointment times and use professional and social contacts to put pressure on the therapist. All of these demands are more representative of the physician's personal anxieties than an effort to control or manipulate the therapy, Dr. Maloney says. Once objections are voiced and parental anxieties are dealt with, therapy for the child often progresses smoothly and successfully, he adds.

Dr. Maloney gives as an example one situation where the physician father of a teenager with anorexia broke three appointments before he finally came in to discuss the situation with her psychiatrist. When he did arrive, he "had a laundry list of complaints about psychiatry," says Dr. Maloney, "and he insisted that his daughter be hospitalized in a clinic 300 miles away. He was hoping for a 'quick fix' solution to his daughter's problem," Dr. Maloney explains. "He was also embarrassed about having to come in himself."

But while an out-of-town clinic would have put the physician more at ease, Dr. Maloney did not feel it was in the best interest of the patient, who would need to develop some ongoing, long-term solutions to her eating disorder. A further discussion revealed the true source of his resistance — the physician's mother, who had suffered from severe emotional problems, had had some bad experiences in treatment, and the physician father feared his daughter would have similar luck. Future sessions also brought out the fact that the physician felt to blame for his daughter's problems — yet he was not ready to cope with his own guilt or feelings of failure.

Once these fears and feelings were aired, both father and daughter agreed to continue treatment locally. "Two years later, this physician father has not missed an appointment," says Dr. Maloney, "and he continues to be instrumental in his daughter's recovery."

No Quick Cures

Another problem commonly experienced in treating the children of physicians is what Dr. Klykylo calls the "VIP syndrome." These children and their parents may be quietly rushed through a program in order to ease the family's embarrassment and to expedite a cure. Unfortunately, says Dr. Klykylo, instead of doing them a favor, these treatment attempts do them a great disservice. Frequently the care ends up being insufficient, says Dr. Klykylo.

The physician parent may not be the only one to resist treatment.

The Children of Psychiatrists — How Do They Feel?

"Your dad's a shrink?"

"What does a psychoanalyst do?"

"Can she read my mind?"

"Will he try to analyze me?"

These are some of the questions that the children of psychiatrists sport from their friends and classmates on a regular basis. Unlike the offspring of other physicians, often admired and befriended for their parent's occupation and status in the community, the children of psychiatrists — like their parents — frequently are surrounded by mystery and kept at a distance by their peers.

In addition, some of these youths themselves find it difficult to understand and explain what it is their parent does behind closed doors, although it is an understanding that comes largely with age. "I used to think my dad worked with crazy people," says the child of one psychiatrist. "Then I grew up and realized that his patients were just people with everyday problems."

Despite the questions and uneasiness that may surround their parent's occupation, most of these children seem to take it all in stride, according to a video tape presented at the June 14 meeting of the Ohio Psychiatric Association. Many even use their parent's occupation and skills to their own advantage.

Seven children, ranging in age from 15 to 22, were interviewed on tape by Michael J. Maloney, MD, director of the division of child psychiatry and psychology at Children's Hospital Medical Center in Cincinnati. Dr. Maloney is also associate professor of child and adolescent psychiatry and pediatrics at the University of Cincinnati College of Medicine.

The youths were asked a wide range of questions dealing with their parent's profession and how they felt about it.

"Many people are shaky about psychiatrists — I end up defending the profession a lot," one remarked.

Several said they found it difficult to explain what a psychoanalyst or psychiatrist was, and so they reverted to the more colloquial term "shrink."

How do their friends typically respond to their parent's profession? Some react with "major hysteria," in one son's words, "until they get to know him (the psychiatrist parent). Then everything's OK."

Others' friends are confused about the psychiatrist's work and are hesitant to visit the home for fear they will be asked too many questions or will be "analyzed."

On the other side of the coin, some friends and classmates feel the children of psychiatrists have "an edge" on other kids where problem solving is concerned. Some of the offspring are even sought out for this purpose — which brings mixed reactions from the youths.

She found herself responding with one of her father's favorite expressions in therapy: "What can I do to make it easier?"

The daughter of one psychiatrist, for instance, confronted with an emotionally upset friend, found herself responding with one of her father's favorite expressions in therapy: "What can I do to make it easier?" And, she added, "It almost worked."

Others felt somewhat resentful that their friends seemed to focus on personal problems around them. And some occasionally consulted their psychiatrist parent for advice to give their friends.

One young man said he had picked up on his parent's ability to be an "empathetic listener." Most also used this skill when answering telephone calls from patients when parents weren't home. The youths interviewed said they made a real effort to support, comfort and reassure patients when the doctor was not at home and to take messages for return calls.

Unfortunately, the patients who are calling are not always equally courteous. "Some are annoying — they hang up or call us 10 times a day," one youngster related. "Some treat families very bad."

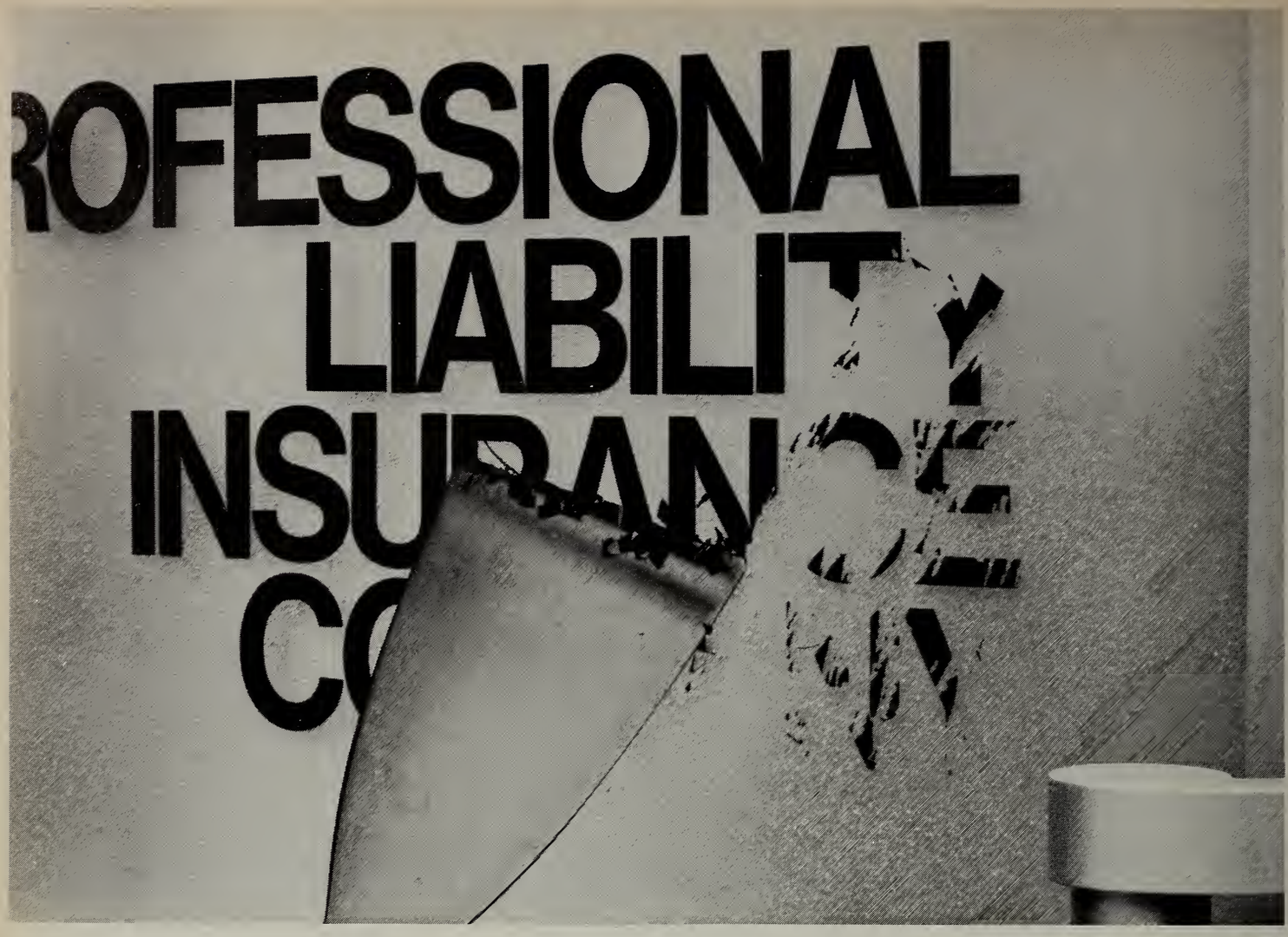
In fact, stress in handling phone calls was expressed frequently by the youth, along with the feeling that the psychiatrist parent was too busy for family life. Some said their parent tried to keep weekends free for family activities, but that evenings were usually out of the question for family time.

In addition, according to Dr. Maloney, some of the children of psychiatrists may feel pressured to achieve academic excellence, since their parents are high achievers. This, he says, can create problems for both child and parent if hopes and aspirations are not adjusted early.

"There is a general feeling in medicine and in the lay public that the children of psychiatrists have more problems than other youths," says Dr. Maloney. His video project, however, did not evidence this and, in fact, showed that these youths were very much in touch with their feelings. Those invited to participate sprang at the opportunity to discuss the impact of their parents' occupation in their lives, he says.

Another common assumption, he adds, is that "you are a much better parent because you're a psychiatrist — you're always understanding, you never shout, you never make mistakes."

Both attitudes, he adds, are largely myth, since no real studies have been done comparing the mental health of psychiatrists' children to that of the population at large. — *Susan Porter*



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The medical profession is intensely and painfully real — so we develop a sense for the importance of real things, as do our children.

The children, too, may have difficulty accepting therapy. "Older children, especially, have a fear of betraying their parents," says Dr. Klykylo. "All kids feel this, to some degree, but if your parent is 'the perfect healer,' you may not want to talk about his or her shortcomings."

Children, like their physician parents, may become experts at denying problems exist. In addition to the proverbial "black sheep" child in the family — the one who acts out his/her frustrations and anxieties in a very visible and sometimes self-destructive manner — there are those children in the medical family who may appear calm and complacent. They may be model students in school and present few behavior problems to their parents. Yet, deep down, they may be severely depressed, withdrawn from friends and classmates, and they may even have suicidal tendencies. Often, says Dr. Maloney, these children are not spotted until another problem — such as marital discord or a disruptive brother or sister — comes out into the open. "There are a lot of gray areas," says Dr. Maloney, "where it hasn't yet impacted on their functioning. We must keep an eye open for this."

Yet with all of the potential for problems, the children of physicians do enjoy some great psychological advantages, the psychiatrists agree. Like their parents, these children are frequently intelligent, hard-working and sensitive human beings, willing to give of themselves for the benefit of others. They are often assertive, conscientious and altruistic, frequently involved in community or charity work, the leaders and the doers at school.

Many of them do well in school, because physicians frequently pass their love of learning along to their children, along with the strong sense of self-satisfaction they receive from their work. For this reason, many of their children go on to become physicians themselves, realizing it is a difficult but worthwhile and obtainable goal. "A lot of adults today do not enjoy the work they're doing," says Dr. Klykylo. "But even with all of its shortcomings, this (medicine) is still very exciting work."

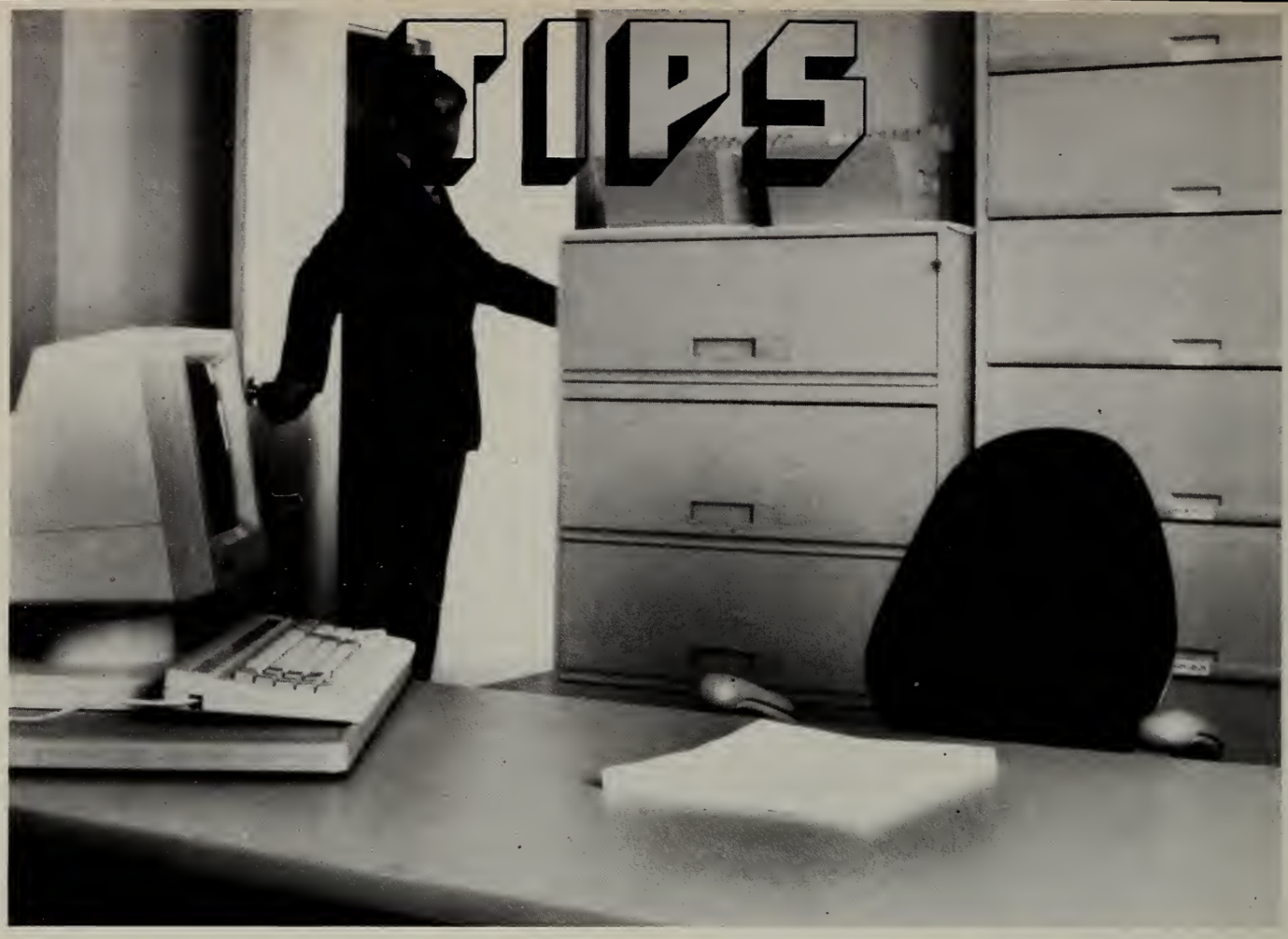
Also, an inherent trait in the medical profession is the knowledge that an individual in society can make a difference and can have a positive impact on the real world. "Our culture today is so involved with things that aren't real," says Dr. Klykylo. "Yet the medical profession is intensely and painfully real — and so we develop a sense for the importance of real things, as do our children."

And finally, all three physicians point out, very few studies have been done which actually compare the mental health of the children of physicians to those of teachers, attorneys, ministers or any other career or professional group. Thus, when all is said and done, says Dr. Klykylo, "I don't think we're any worse off or any better off than any other professional group. We each have our own special needs."

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Susan Porter is the Associate Editor of the **Ohio State Medical Journal.**



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and role models, they like to appear very self-reliant — needing no intimate relationships or support systems. This is coupled with the fact that many addicted physicians come from alcoholic homes (25-50% of all freshman medical students come from alcoholic homes) and also have these issues to deal with. We have a treatment population that is bright, controlling, and skillful in avoidance and blocking feelings and is also fearful that self-revelation will unfavorably impact on their careers. Because of their high value systems, they also are likely to have a very heavy burden of guilt of which they may not be acutely aware. To complement this, their families tend to be equally highly impaired because they have tried to protect the breadwinners' image as they go on their destructive course. The typical family member is depressed, angry, guilty, with low self-esteem, and has been competing with the chemically dependent family member for control of the family.

Our experience and that of others is that physicians tend to be further advanced in their disease of chemical dependency than non-physician patients and that they demonstrate more pathology — physically, psychologically, sexually, and spiritually. Because of their highly defended defense and denial mechanisms, they will go to any lengths to deny the significance of the problem. These are formidable obstacles to treatment. We feel strongly that an individualized treatment plan is essential using a skilled and multi-disciplinary treatment plan. Physicians are probably best treated in a facility and not in their home community for obvious reasons. It is essential that the family be involved in the treatment experience, and in our experience the family members may have impairment equal to or exceeding that of the chemically dependent physician. We believe it is essential that we develop a liaison with the licensing board if necessary, the employer and the other physicians in their community who will provide support. This should all be done within the very strict guidelines of confidentiality and with respect to the privileged physician/patient relationship. We also think it is essential that the potential for suicide be very carefully evaluated, but we feel the risk is already diminishing when the physician accepts treatment.

Our experience is that in Phase I of our program, the inpatient treatment, we usually are able to assist physicians with extensive education and peer group therapy to accept their disease of addiction as well as to make them aware of their strenuous unsuccessful efforts to control their addiction and to begin to recognize their powerlessness and the unmanageability of their lives. This is the first step of the AA self-help program. In addition, they usually have begun to dismantle their pathological defenses and accept their humanity as well as to bond with a therapy group. They also are frequently ready to identify their spirituality and their needs to rehabilitate their spiritual life.

Early in the course of treatment, the physician is introduced to the Caduceus Club. The Caduceus Club provides a fellowship experience as well as monitoring and surveillance, and this continues throughout the two-year treatment program. It also gives assurance to the new, frightened physician and family that recovery is not only possible but likely.

When the physician enters the Central Ohio Recovery Residence in Phase II, s/he is then ready for more intensive group dynamics and is beginning to identify personality traits that s/he wishes to change in that supportive setting. The setting in the Recovery Residence is that of a surrogate family with seven to eight members. This is a time when we see a rather dramatic emotional and spiritual growth and development of a level of intimacy that frequently the physician has never known before.

When the physician has completed Phase II of the program, s/he commences Phase III, which is Mirror Image, i.e. returning to her/his professional life as a physician/patient working with other chemically dependent patients in one of a number of treatment facilities around central Ohio. S/he learns to accept her/himself in a role of recovering physician as well as becoming increasingly more familiar with the progressiveness of the disease of chemical dependency.

We believe in treatment contracts. Of course, these contracts are not legally enforceable, but our experience is that physicians who negotiate a contract are likely to live up to it. We insist on a two-year monitoring period, which gives us credibility for our advocacy role with hospitals, practice groups, licensing boards, etc.

In medicine there is always controversy, particularly in an evolving field such as chemical dependency, as to what constitutes the optimum therapeutic regimen. Our program has stood the test of time with more data for our model as to effectiveness than any other. We feel with the issues involved, i.e. the lives and careers of physicians as well as their families, we should continue treatment at this level with its guarantee of a high success rate. Perhaps the most important lesson that our experience has taught us is that when adequately motivated and with appropriate treatment, physicians do recover.

William J. Kennedy, MD, is Medical Director of the Shepherd Hill Hospital in Newark, Ohio.

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Report from the AMA's Business Meeting

By Oscar W. Clarke, MD and John E. Albers, MD

How Ohio voted . . .



This report covers some of the important issues voted on by the Ohio Delegation at the 1986 Annual Business Meeting of the American Medical Association in Chicago, Illinois, June 15-19, 1986.

There were 83 reports and 144 resolutions considered by the House of Delegates. The following report contains seven of the resolutions submitted by the Ohio Delegation to the AMA.

Specialty Society Representation in the AMA House of Delegates

The American Medical Association House of Delegates amended and adopted a resolution submitted by the Ohio Delegation as follows:

"RESOLVED, That the American Medical Association Board of Trustees again study the issue and criteria for admission of specialty societies for representation in the AMA House of Delegates and report to the House of Delegates at the 1986 Interim Meeting; and be it further

RESOLVED, That a moratorium be imposed on additional Specialty Society Representation in the House of Delegates until the study requested is reported to the House."

Foreign Medical Graduates

The American Medical Association House of Delegates amended and adopted a resolution submitted by the Ohio Delegation as follows:

"RESOLVED, That the American Medical Association continue to work to protect the rights and privileges of all physicians duly licensed in the United States regardless of ethnic or educational background; and be it further

RESOLVED, That the AMA oppose any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background."

Mandated Professional Liability Insurance

The AMA House of Delegates rejected a resolution from Ohio that calls on the AMA to work with the American Hospital Association to address the question of insurance carriers' mandated minimum limits of professional liability insurance for members of medical staffs; develop guidelines specifying the rights of medical staffs and governing bodies concerning medical professional liability insurance; oppose the practice of hospital governing bodies and insurance companies requiring minimum amounts of insurance as a condition for medical staff membership; and oppose efforts to amend medical staff bylaws as a condition for

insurance. Existing AMA policy, articulated in Report T of the Board of Trustees (I-79), states that:

"If the organized medical staff makes this determination (to require specified limits of liability insurance for membership), the members of the medical staff should comply with the requirement."

In addition, such a requirement has been upheld as legal in nine jurisdictions. In one recent case, brought by physicians against a hospital and an insurance company, the court decided against the physicians. Existing JCAH standards cite "current evidence of adequate professional liability insurance" as a reasonable qualification for clinical privileges.

Support of a Tobacco-Free Society

The American Medical Association House of Delegates adopted the following substitute resolution in lieu of eight resolutions, including one from Ohio, on the subject of tobacco:

"RESOLVED, That the American Medical Association continue to support a tobacco-free society by the year 2000 through enactment of the following policies:

"RESOLVED, That the American Medical Association continue to support a tobacco-free society by the year 2000."

1. That smoking be prohibited at all meetings sponsored by the AMA, and that proactive non-smoking policies be developed for the AMA membership and staff.
2. That the American Medical Association endorse the passage of laws, ordinances and regulations that would prohibit smoking in public buildings and facilities, prohibit vending machine sales of cigarettes and tobacco products and set the minimum legal age for purchasing tobacco products at 21.
3. That the AMA pursue its position for federal legislation to raise the federal excise tax on cigarettes with revenue from the increase being apportioned to Medicare.
4. That the AMA endorse legislation to prohibit smoking and the sale of tobacco products in health care institutions.
5. That the AMA develop and endorse legislation calling for a smoking ban on all commercial airline flights within the continental United States.
6. That the AMA continue to support strong education efforts, from kindergarten through the 12th grade, to help pre-teens, adolescents and young adults avoid the use of tobacco products, including smokeless tobacco.
7. That the AMA encourage appropriate school authorities to prohibit the use of all tobacco products by students, faculty and coaches during the school day and during other school-related activities.
8. That the AMA encourage the incorporation of appropriate intervention program with existing educational programs as they are developed.
9. That the American Medical Association Board of Trustees inform all appropriate national medical-oriented organizations of the importance of AMA policy which expresses opposition to federal support to the tobacco industry (Resolution 77, A-85) and, further, urge and challenge other organizations to take similar action.
10. That the American Medical Association encourage state and county medical societies to recognize and to express appreciation to any broadcasting company in their area that voluntarily declines to accept tobacco advertising of any kind.
11. That the American Medical Association oppose the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products.
12. That the American Medical Association develop an appropriate body for coordinating and centralizing the Association's efforts toward a tobacco-free society.

Standardization of Preadmission Certification Criteria

The American Medical Association House of Delegates adopted the following resolution submitted by the Ohio Delegation to the AMA:

"RESOLVED, That the American Medical Association seek standardization of administrative procedures for preadmission certification programs, including both the administrative requirements to be met and the forms to be completed."

In addition, the AMA House of Delegates adopted a Council on Medical Service report which includes the following principles for evaluation:

1. Blanket preadmission review of all or the majority of hospital admissions does not improve the quality of care, and should not be mandated by government, other payors, or hospitals.
2. Policies for review should be established by state or local physician review committees, and the actual review should

be performed by physicians or under the close supervision of physicians.

3. Adverse decisions concerning hospital admissions should be finalized only by physician reviewers and only after the reviewing physician has discussed the case with the attending physician.
4. There should be direct and continuing communications to physicians and insureds, regarding prior authorization requirements.
5. All preadmission review programs should provide for immediate hospitalization, without prior authorization or subsequent denial of payment based on lack of such authorization, of any patient whose treating physician determines the admission to be of an emergency nature.
6. No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review or solely on the fact that hospitalization occurred in the face of a denial for such admission.
7. Payors who institute preadmission review requirements as a condition for benefits should be subject to legal action for any harm incurred by the patient resulting from application of such requirements.
8. When inordinate amounts of physician time or effort are involved in complying with preadmission review requirements, the physician may charge the payor or the patient for the reasonable cost incurred.

Standardization of Mandatory Second Surgical Opinion Programs

The American Medical Association House of Delegates adopted the following substitute resolution in lieu of a resolution submitted by the Ohio Delegation:

"RESOLVED, That the American Medical Association urge third party payors who require second opinions to inform their subscribers so that they understand the requirements of such programs."

Physician Reimbursement for Home Health Care

The American Medical Association House of Delegates amended and adopted a resolution submitted by the Ohio Delegation as follows:

"RESOLVED, That the American Medical Association urge third party payors to allow for remuneration consistent with services rendered by physicians involved in treating patients at home."

Fees for Services When Fulfilling Third Party Payor Requirements

The American Medical Association House of Delegates filed a Council on Ethical and Judicial Affairs report advising that physicians may properly seek to be compensated when third party payors require reports that necessitate extensive or complex services. The report further advises that such action would not be in violation of the Council's ethical opinions.

In addition, the AMA House of Delegates adopted an amended report of the Council on Medical Service recommending that the attending physician should perform without charge simple administrative services required to enable the patient to receive his benefits. When more complex administrative services are required by third parties, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay and other authorizations as a condition of payor coverage, it is the right of the physician to be recompensed for his incurred administrative costs.

Campaign Procedures and Expenses — AMA Election Process

The American Medical Association House of Delegates

When more complex administrative services are required by third parties, it is the right of the physician to be recompensed . . .

amended and adopted a report of the Special Committee to Study Campaign Procedures and Expenses stating that the AMA election process is working well and will continue to provide the Association with high-caliber leadership. While the level of campaign expenditures appears to have stabilized in recent years, the report urges sponsoring societies to continue to use restraint in planning campaign activities. The report also stressed that campaign mailings should be curtailed and telephone solicitations should be discouraged in future campaigns. The report also recommends that:

1. The AMA prepare a prototype election manual for consideration by members of the House of Delegates. Such manual might reduce campaign mailing expenses.
2. The announcement of the Council nominations and the official ballot list candidates in alphabetical order by name only.
3. The Speakers continue to urge fiscal restraint in planning campaign activities which could include a meeting of candidates and campaign managers if the Speakers determine such a meeting is necessary and appropriate to accomplish that result.

Report from the AMA's Business Meeting . . . *continued*

Proposal for Financing Health Care for the Elderly

The AMA House of Delegates adopted an amended Board of Trustees report that presents a comprehensive proposal calling for elimination of the current Medicare program but honoring commitments already made to the elderly. It calls for individuals to contribute during their working years enough money to simultaneously fund future health care for those now working and contributing to the program, and, at first, defray the costs of caring for those who are now Medicare beneficiaries. Major features of the program include:

1. Creating a publicly managed trust fund reserved for the individual's purchase of private health insurance in old age.
2. Eliminating immediately the health insurance payroll tax on individuals and replacing it with a flat-rate tax on adjusted gross income up to $100,000. The tax rate would be based on the actuarial costs of accumulating a fund for the provision of health insurance that would offer adequate benefits on retirement for those now working, and for those who are currently retired.
3. Eliminating immediately the federal government's general revenue obligation to the Medicare Part B trust fund, which totaled some $18 billion last year.
4. Allowing additional tax-exempt contributions to Individual Retirement Accounts of $500 for an individual and $1,000 for a husband/wife. Additional tax-free withdrawals from IRA's would be allowed for health expenditures after reaching the age of eligibility. That age of eligibility would be increased to 67 from the current 65, at the rate of three months per year.

The program would provide catastrophic protection along with equitable means testing. Out-of-pocket spending limits for most beneficiaries would be $2,500 per year for individuals and $3,750 for families. These limits would be reached by combining a uniform coinsurance limit with a deductible based on income.

The report presents a comprehensive proposal calling for elimination of the current Medicare program, but honoring commitments already made to the elderly.

Delayed Payment of Medical Insurance Claims

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association seek means by which the problem of delayed Medicare reimbursements for physicians' services can be ameliorated, and express its concern and displeasure to the Health Care Financing Administration (HCFA) about the practice of slowing payment of Medicare claims (including the recent consideration of a 28-day payment cycle), which would place an unwarranted financial burden upon the elderly, the practitioners and facilities which serve senior citizens; and be it further

RESOLVED, That the AMA attempt to develop model state legislation to establish incentives and/or penalties among private and public third party payors toward rectifying the problem of delayed insurance reimbursements, and be it further

RESOLVED, That reasonable interest should begin on controverted claims no later than 30 days after receipt by the payor."

Mandated Medicare "Participation"

The American Medical Association House of Delegates adopted the following amended resolution:

"RESOLVED, That the American Medical Association develop a mechanism to provide AMA expertise to states where mandatory assignment initiatives or attempted legislative actions are underway in order to help preserve Medicare's current provisions that allow physicians and patients to determine individually the need for, and appropriateness of, accepting assignment for services provided.

Concept of a "Gatekeeper"

The American Medical Association adopted a report of Council on Medical Service in lieu of several resolutions. The report presents a comprehensive review of the "gatekeeper" concept, discusses positive and negative aspects of this approach, notes the Council's distaste for the term "gatekeeper," and recommends that the current AMA support for pluralistic and competitive health care delivery systems continues to be appropriate with respect to "gatekeeper" systems. The report noted that in a number of respects, the "gatekeeper" function is similar to the services traditionally provided by any practitioner who serves as the patient's primary physician — initial access to the health system, continuing responsibility for comprehensive care including prevention, and arranging and coordination of other care resources needed. It may differ from the traditional primary physician's role in two respects, however:

(a) Access to other needed care is usually *only* through the primary physician — the patient cannot seek the services of other health professionals or resources directly; and

(b) The primary physician may be at financial risk for the cost of services provided, either through capitation or other arrangements for financial reward or penalty based on the physician's performance in controlling costs.

Potential advantages unique to the "gatekeeper" approach are:

1. Stronger incentives toward prudent use of resources; and
2. The elimination of duplicative services.

Potential disadvantages to the "gatekeeper" approach are:

1. An incentive to underserve patients;
2. Possible delays in obtaining needed secondary or tertiary services; and
3. The provision of such services by less qualified practitioners, as well as restriction on the patient's freedom of choice of the specialized provider.

The report further states that in practice, however, the benefits and limitations of "gatekeeper" systems are difficult to document, as evidence of their impact on costs and quality of care is either inconclusive or lacking to date.

The AMA will continue to monitor studies regarding the "gatekeeper" concept and will report further to the House of Delegates as appropriate.

Durable Power of Attorney for Health Care

The American Medical Association House of Delegates adopted a Board of Trustees report which responds to an earlier resolution that calls upon the AMA to "develop and circulate model state legislation patterned after California's Durable Power of Attorney for Health Care statutes." The resolution also recommended that the AMA actively encourage all state medical societies to consider efforts to achieve passage of such legislation in their states. The report sets out the activities of the Board of Trustees and the Council on Legislation in developing model legislation on this subject. It was noted at the hearing that laws in addition to California's are under review, and that model legislation should be available within the next few months.

Report of the Special Task Force on Professional Liability Insurance

The American Medical Association House of Delegates adopted a Board of Trustees report of the AMA's Special Task Force on Professional Liability and Insurance in lieu of several resolutions. The following is a brief summary of the significant events and projects of the Task Force during the last six months:

Federal Legislation

The Hatch-Inouye-Lent Bill — The AMA's federal legislation which provides financial incentives to states which pass tort reform is now sponsored by six senators and over forty congressmen. Hearings on the bill and other liability proposals produced substantial testimony in Congress and generated a better national understanding of medical professional liability.

Alternatives to Traditional Tort Reform

AMA's Professional Liability Action Plan proposed a continuing search for effective alternatives to traditional tort reform. Through the AMA coalition of national specialty societies, a comprehensive study of alternatives is taking place. By the 1986 Interim Meeting, or shortly thereafter, a special team of consultants will provide the first careful investigation of existing alternative proposals and will examine new approaches as well.

Coalitions

AMA-National Medical Specialty Societies — The AMA, 32 national specialty societies and the Council of Medical Specialty Societies have formally joined in a coordinated effort on several professional liability projects.

Other Coalitions — The coalition of 140 national organizations which AMA assembled in December of last year completed its report, "The Need for Legislative Reform of the Tort System," in May. Most members of this coalition have joined the American Tort Reform Association (ATRA). AMA representatives sit on ATRA's Board of Directors and Steering Committee. ATRA, together with the Chamber of Commerce, is leading the national efforts to translate the consensus for reform of the legal system into legislative action. Economic research, information sharing, federal testimony, model state legislation and national public relations are central activities of these organizations.

New Association of Trial Lawyers of America Response

The AMA, again in conjunction with the national medical specialty societies, is preparing a report which will address the current confusion and misconceptions about the liability crisis. This report will pull together a variety of credible sources of information, data and analysis to refute the second wave of false or misleading assertions by ATLA and various self-styled "consumer" groups. Among the issues to be addressed are the number of claims and suits, the severity of awards, the role of the insurance industry, the

AMA's Professional Liability Action Plan proposed a continuing search for effective alternatives to traditional tort reform.

impact of the incompetent physician, the effectiveness of tort reform and the effect of legal system reforms on individual rights.

Risk Management, Peer Review and Discipline

AMA has announced a new initiative on self-regulation which proposes several immediate steps to improve the discipline system: A call on physicians and medical societies to vigorously fulfill their ethical duty to report substandard practices and practitioners; expansion of AMA's Physician Masterfile to include HHS and hospital discipline data; and Justice Department cooperation in advising physicians of peer review procedures which reduce or eliminate the risk of antitrust liability.

Center for Health Policy Research

A professional liability clearinghouse has been established within the AMA's Center for Health Policy Research. The clearinghouse has produced a comprehensive bibliography of material pertaining to professional liability, which is being distributed to state, county and specialty societies. In addition, the Center will continue to perform independent research on liability issues. Among its priorities are: Facts on Professional Liability; study of the medical liability insurance industry; and study of physician exposure to malpractice risk.

"RESOLVED, That the American Medical Association study the desirability of establishing "liability courts" which would process professional liability cases."

Public Relations

The Division of Communications continues to generate opportunities for the American Medical Association to explain to the press and the public the crisis in professional liability.

Liability Courts

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association study the desirability of establishing "liability courts" which would process professional liability cases."

Medical Society Referrals

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association Board of Trustees examine and report back to the House of Delegates at the December 1986 meeting on the potential antitrust implications of medical society referral programs, to include suggested options for satisfying any concerns and, if necessary, legislative proposals."

Childhood Immunization

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association increase its efforts to aggressively resolve the liability crisis in respect to childhood vaccines by urging Congress to immediately enact tort reform which would allow for the safety, efficacy and availability of childhood vaccines at a conscionable cost."

Report of the AMA Task Force on Physician Manpower

The American Medical Association House of Delegates adopted an amended Board of Trustees report that recommends the following:

1. That the AMA carry out extensive, ongoing analyses on physician manpower issues;
2. That the AMA encourage the U.S. medical education system to review data and analyses regarding physician supply and its impact on the quality and cost of care so that educators can appropriately establish the size of total enrollment.
3. That the Council on Medical Education continue to monitor closely the relationship between the size of medical school enrollments and the quality of educational programs.
4. That the AMA support repeal of federal legislation and regulations that mandate maintaining specified enrollment in U.S. medical schools, and that the AMA encourage the repeal of any state laws mandating maintenance of specified enrollments at state-supported medical schools.
5. That the AMA continue to actively support policies that maintain appropriate quality standards and criteria for the practice of medicine. Accreditation criteria must always be based solely on reasonable quality standards and may not be used for any other purposes. Where concerns about quality are documented, accrediting bodies have an obligation to take

corrective action, regardless of the secondary effects.

6. That the AMA more actively disseminate to the general public information about the changing characteristics of medical practice and the medical community.
7. That the AMA coordinate efforts with the state medical societies to provide state legislators and administrators with information that will allow them to determine which health manpower policies are best suited for their states.
8. That the AMA work toward a more favorable geographic distribution of physicians by making efforts to provide physicians with more extensive information with which to make their location decisions.
9. That medical students be provided with appropriate information so that they can best make their choice of specialty training.
10. That the AMA institute programs which would assist physicians seeking a transition from a full-time practice.

Ad Hoc Committee on Foreign Medical Graduates

The American Medical Association adopted an amended Board of Trustees report of the Ad Hoc Committee on Foreign Medical Graduates in lieu of a resolution on the same subject. The lengthy report included thirty recommendations on the following subjects:

1. Visa and Immigration Requirements
2. Foreign Medical Schools
3. Developing and Assessing Clinical Skills
4. Credentialing of Physicians
5. Participation in Organized Medicine
6. International Relations and Medical Education

Economically Motivated Patient Transfers

The American Medical Association House of Delegates adopted an amended Council on Medical Service report that provides background information on the practice of transferring patients from one facility to another for financial reasons. The report contains four recommendations: That the AMA adopt three "Principles for the Transfer of Emergency Patients"; that county medical societies be urged to develop, with hospitals, protocols and inter-hospital transfer agreements to address economic transfer; that state medical associations be urged to encourage and assist county medical societies in these activities; and that the Council on Medical Service continue to study the issue of emergency patient transfers for economic and non-economic reasons, including transfers mandated by pre-paid health plans.

In addition, the AMA House of Delegates referred the following resolution on the same subject to the Board of Trustees for a report at the earliest possible date:

"RESOLVED, That the American Medical Association work with all interested parties to assure that the Health Care Financing Administration recognize the existing "Guidelines for Transfer of Patients" from the American College of Emergency Physicians, American College of Surgeons, and local or state Emergency Medical Services' Systems plans when developing rules, regulations, and guidelines; and be it further

RESOLVED, That the AMA work with all interested parties to assure adequate patient economic support to maintain high quality care; and be it further

RESOLVED, That the AMA closely monitor the effects of H.R. 3128 on the quality of patient care and report back no later than the Interim 1986 Meeting."

Public Awareness Activities

The American Medical Association House of Delegates adopted an amended report of the Board of Trustess that presents the report of the Advisory Committee to the AMA Public Awareness Program and includes a set of recommendations related to the Association's continuing public awareness activities. The recommendations propose that the highest emphasis continue to be placed in this area; suggest a variety of prioritized activities for possible implementation; indicate that a report outlining a National Public Awareness Campaign including resource requirements be developed for the 1986 Interim Meeting; and stipulate that the work of the Advisory Committee be concluded with an expression of appreciation.

The report recommends that the AMA carry out extensive, ongoing analyses on physician manpower issues.

Quality of Care

The American Medical Association House of Delegates adopted a Council on Medical Service report that outlines the Council's study of ways to preserve the quality of care including definitions of eight "essential elements of quality" as well as a series of guides for quality assessment.

In addition, the AMA House of Delegates referred the following resolution on the same subject:

Report from the AMA Business Meeting . . . *continued*

"RESOLVED, That the American Medical Association establish a study committee to determine the most effective legal way to allow negotiations on behalf of physicians regarding standards and quality of care."

Liability and Financial Responsibility for Injuries to Patients Consequent to Review Decisions by Third Party Payors

The American Medical Association House of Delegates adopted a Council Medical Service report that recommends development of legislation that would require peer review organizations, fiscal intermediaries, insurance companies and other third parties to accept liability and financial responsibility for injuries to patients resulting from improper review decisions.

Confidentiality of Peer Review Records and Immunity of Peer Review Committees

The American Medical Association House of Delegates referred the following amended resolution:

"RESOLVED, That the American Medical Association urge state medical associations to support enactment of legislation that will provide a state action exemption to protect peer review activities within their states; and be it further

RESOLVED, That the American Medical Association seeks federal legislation to protect peer review records from discoverability and introduction into evidence in anti-trust actions and to provide immunity of peer review committees whose members perform their work in good faith."

AMA Masterfile

The American Medical Association House of Delegates referred the following resolution to the Board of Trustees for action:

"RESOLVED, That the American Medical Association inform hospital medical staffs and county medical societies of the availability of the valuable information contained in the AMA Physician Masterfile."

There are many excellent reports presented to the House of Delegates at each meeting, covering a wide range of subjects that are of interest to physicians. These reports, prepared by the AMA Board of Trustees, councils, committees and staff, contain a wealth of information.

A listing, by title, of some of the reports follows. If you would like a copy of any of these reports, please contact the OSMA office.

1. Joint Commission on Accreditation of Hospitals
2. Same-Day Admission and Outpatient Surgery
3. State Legislation to Monitor Prescription of Schedule II Drugs
4. Restructuring the Medicare Law
5. Medicare and Medicaid Administration
6. Health Policy Agenda for the American People — Current Status
7. AMA Policy and Programmatic Activities For An Aging Population
8. Handicapped Physicians
9. Final Report of the AMA Task Force on Physician Manpower
10. Report of the Ad Hoc Committee on Foreign Medical Graduates
11. Legal Status of the Hospital Medical Staff
12. Hospital Medical Staff Joint Ventures: An Update
13. A National Study of Resource-Based Relative Value Scales for Physician Services: Project Update
14. Health Care of the Homeless Population
15. Report of the Special Task Force on Professional Liability and Insurance
16. Funding Graduate Medical Education
17. Malpractice Coverage for Residents and Fellows
18. Quality of Care
19. Prior Authorization Programs
20. AIDS and School Discrimination
21. Safe Use of Radioactive Materials in Medical Practice
22. Herpes Simplex and School Children
23. The Heimlich Maneuver
24. Drugs and Athletes

Please send me the following AMA report(s) listed in the Summary of Actions Report of the 1986 AMA Annual Meeting:

Report Number(s) _____

Name: _____

Address: _____

_____

Send to: The Ohio State Medical Association
600 South High St.
Columbus, Ohio 43215

Minutes of the OSMA/MSS Annual Meeting

By Peter D. Spatt and Judith Lavrich

Columbus, Ohio
February 22, 1986

I. Meeting was called to order by Judith Lavrich (UC), President, at 9:00 a.m. In attendance were:

CWR:	Peter Eckel
MCO:	Naakesh A. Dewan, Joel Gelman, Karen Guss, Brian Jewell
NEOUCOM:	Stacey Hollaway, Jill Pendleton, Christopher Rocco, Dianne Wu
OSU:	Michael Aruta, Nita Arora, Jonathan Baktari, Charles Bogdan, Michael Dick, Melissa Lim, Jeff Oehler, Don Sullivan, Linda Woodyard, Cathy Yeagley
UC:	Tim Beer, Steve Gilreath, Judy Kramer, Judith Lavrich, Mark Rutkowski
WSU:	Kevin Clark, Derrick Jeter, Jeff Kittle, Denise Reeves, Peter Spatt
OSMA:	David Torrens

II. Minutes of the 1985 Annual Meeting were approved after noting the incorrect recording of Stephen Gilreath as Judith Gilreath.

III. Judy Lavrich reminded the assembly of the use of Sturgis' Rules for parliamentary procedure. It was noted that Dr. Oscar Clarke would not be able to address the assembly due to his involvement in the National Leadership Conference.

IV. REPORTS

A. AMA-MSS Report, Brian Jewell (MCO) Vice President. Brian explained to the assembly the structure of the AMA, AMA-MSS, OSMA, and OSMA-MSS, making use of the flow diagram under tab 4 in our delegate manuals. He explained that the AMA-MSS meets twice a year, once in June at the Annual Meeting in which officers are elected as well as for the conduction of normal business, and again in December at the Interim Meeting which is a business meeting. He reviewed for the assembly the various resolutions acted upon by the AMA-MSS assemblies at the A-85 and I-85 meetings. He reviewed the action taken on many of the resolutions at the June meeting, particularly the resolutions on the: Good Samaritan Law, Drug Evaluation Guides, Smokeless Tobacco Legislation, Nitrates and Sulfates Legislation, Emergency Medications on Airlines, Medical Financing of Medical Education, Anti-Abortion Film "Silent Scream," Teen Pregnancy, Cigarette Advertising, Mandatory Seat Belt Legislation, Residency Funding, and Child Abuse.

The OSMA/MSS Annual Meeting . . . *continued*

From the December meeting Brian informed the assembly of the particularly good showing made by the Ohio delegation, such as in placing delegates on various national committees. The assembly was informed of action taken by the OSMA/MSS Governing Council in proposing to the Ohio AMA delegation of the inclusion on the delegation of a student, which was accepted and will be voted upon by the OSMA State Convention in May. The assembly was informed that Joel Gelman (MCO) was voted by the Governing Council as Alternate Delegate to serve on the Delegation should the resolution be approved, with the position in following years being decided by the OSMA/MSS assembly at the Annual Meeting. Various proposals acted upon at the I-85 meeting involved Blood Transfusions Education, Elderly Abuse, Smoke-Free Education Program, Public Education on AIDS, Public Image of Physicians, and Organ Donation Legislation.

B. Student Members of OSMA Standing Committees: Committee on Membership. Joel Gelman submitted a written report which related that students would be involved in the recruitment of new members to OSMA by a letter writing and phone campaign. The letter writing campaign would involve students signing preprinted letters which would then be addressed and sent to prospective members. This would be followed up by phone contact. Computer printouts of non-members were made available to delegates at the assembly. An incentive award program was explained in that recruiters would be awarded the equivalent of 10% of the new dues collected from their individual recruitment efforts, to be applied to their meeting expenses for OSMA or AMA meetings, or to their tuition. Joel's report was approved and accepted for filing.

C. OSMA-MSS Reports.

1. Secretary's Report. Peter Spatt (WSU) reported in general of the proceedings at three Governing Council meetings held on Sept. 7, Oct. 6, and Jan. 19. He informed the assembly in particular of the Freshman Orientation Programs, discussion of the Nurse Practice Act, need for student attendance at county and district meetings, OSMA Journal article ideas, status of PICO, funding of student membership in OSMA and AMA, Alternate Delegate Resolution action, and ideas for bylaws changes. He emphasized that each school delegate should have a copy of Governing Council minutes and that they can be inspected at request.

2. Committee on Long Range Planning. Joel Gelman submitted a written report. The report mentioned the action taken by the Ohio AMA delegation to unanimously approve a resolution to create a slot for a student to serve as an alternate-delegate on the Ohio delegation, and this will be voted upon at the OSMA 1986 state convention. For approval, it would require a ⅔ vote since it is a bylaws change in the OSMA constitution. Joel's report was approved for filing.

3. Case of the Month. Derrick Jeter (WSU) submitted a written report which related that the scope of the Case of the Month project was beyond the resources of the Committee at present. A questionnaire included as part of the report for assembly members addressed this interest and commitment level which students have for the project.

4. AMA Alternate Delegate, Joel Gelman. As nominee of the OSMA/MSS Governing Council to serve as the first student alternate delegate on the Ohio AMA delegation, Joel gave his views on his new role. He saw himself as allied to both student and physician interests, in that he wishes to address present and future concerns. He emphasized that he will seek student input on ideas.

V. Elections — Nominations and Speeches.

President:	Brian Jewell
Vice-President:	Cathy Yeagley (OSU)
Secretary:	Mike Aruta (OSU), Derrick Jeter, Steve Gilreath (UC)

VI. Presentation of Resolutions.

MSS 1-86. AMA Alternate Delegate from the OSMA/MSS.
ACTION TAKEN: Passed.

MSS 2-86. Recognition of City of Cincinnati for new Anti-Smoking Ordinance.
ACTION TAKEN: Passed.

MSS 3-86. (Substitute Resolution) Reduction of Ohio's Maximum Legal Blood Alcohol Content for Motor Vehicle Operation.
ACTION TAKEN: Not Passed.

MSS 4-86. Referencing Data in Resolutions.
ACTION TAKEN: Not Passed.

MSS 5-86. Bylaws Change (Defining duties of Vice-President).
ACTION TAKEN: Passed.

MSS 6-86. Bylaws Change (Recommendation powers by OSMA-MSS Governing Council regarding replacing school delegates).
ACTION TAKEN: Passed as amended.

MSS 7-86. All-Ohio Medical School Basketball

Tournament.
ACTION TAKEN: Passed as amended.

MSS 8-86. Impaired Health Providers.
ACTION TAKEN: Referred to OSMA Council.

MSS 9-86. Computer Network to Identify Persons who have Filed Malpractice Suits.
ACTION TAKEN: Passed as amended.

MSS 10-86. Pediatric Emergency Care.
ACTION TAKEN: Passed as amended.

MSS 11-86. Sex Eduation.
ACTION TAKEN: Referred to Council.

MSS 12-86. Bylaws Change (OSMA support for Interscholastic Events).
ACTION TAKEN: Not a bylaws change; passed as amended.

MSS 13-86. Operating Funds for OSMA Organizations at the Medical School level.
ACTION TAKEN: Not Passed.

MSS 14-86. Living Wills.
ACTION TAKEN: Passed as amended.

MSS 15-86. Formal Policy by OSMA Concerning Student, Resident, or Staff Health Care Professional Infected by HTLV-III.
ACTION TAKEN: Referred by OSMA/MSS Governing Council.

MSS 16-86. Biannual Review of Bylaws.
ACTION TAKEN: Passed.

MSS 17-86. Evaluation of Local MSS Chapter Intrastructure.
ACTION TAKEN: Passed.

MSS 18-86. Objectives for the Year.
ACTION TAKEN: Passed as amended.

VII. Elections to 1986-87 OSMA/MSS Governing Council.

President:	Brian Jewell
Vice President:	Cathy Yeagley
Secretary:	Steve Gilreath

VIII. Delegates to the 1986 OSMA Annual Meeting.

CWR:	Peter Eckel
MCO:	Brian Jewell
NEOUCOM:	Chris Rocco
OSU:	Cathy Yeagley
UC:	Richard Bahner
WSU:	Peter Spatt

IX. Final Remarks and Adjournment.

Judy Lavrich was thanked for her leadership during the past year. Dave Torrens was thanked by the Governing Council for his help. The 1986 OSMA/MSS Annual Meeting was adjourned at approximately 4:30 pm.

Respectfully submitted,
Peter Spatt
OSMA/MSS Secretary

Disposition of Resolutions Acted Upon

Resolution 1-86

RESOLVED, that an Alternate Delegate to the AMA House of Delegates shall be elected by the OSMA/MSS Governing Council for the year 1986 and thereafter by the OSMA/MSS Annual Assembly for a one year term in accordance with the Constitution and Bylaws of the OSMA and the Bylaws of the OSMA/MSS; and, be it further

RESOLVED, that the OSMA/MSS Bylaws be amended as follows to allow for such an election: "Chapter XV — AMA Alternate Delegate. An alternate delegate to the American Medical Association House of Delegates shall be elected by the OSMA/MSS Annual Assembly for a one-year term. Nominations for the AMA Alternate Delegate shall be made by the OSMA/MSS Governing Council to the Assembly and election shall be by majority vote of the assembly in accordance with the OSMA bylaws. During the election process, the OSMA/MSS President will place a vote in private to be counted only in the event of a tie. In the event that three (3) or more candidates are running and a tie between two (2) candidates for the most votes is tallied, then a runoff election between the top two candidates shall follow. The Alternate Delegate elected shall assume office at the time of election and shall be eligible for re-election so long as student status is maintained. Any vacancy shall be filled by an OSMA/MSS member selected by the OSMA/MSS Governing Council until such vacancy can be filled by election at an OSMA/MSS Assembly."

MSS Assembly Action: Passed.
OSMA House Action: Adopted.
Joel Gelman, the Medical Student Section representative from Medical College of Ohio, Toledo, was elected to fill this position for 1986-87. (OSMA Resolution 01-86)

Resolution 2-86

RESOLVED, that the OSMA/MSS Governing Council develop a resolution commending

the City of Cincinnati and its Board of Health for their efforts in attempting to reduce the smoking hazards for its citizens in public places, and encourage the OSMA to do the same on behalf of Ohio's physicians.
MSS Assembly Action: Passed.
OSMA House Action: Combined with Resolutions 35-86, 36-86, 38-86, 39-86, 40-86, E.R. 03-86, E.R. 04-86, titled Substitute Resolution No. 35-86. The substitute resolution was adopted.

Substitute Resolution 3-86

RESOLVED, that the OSMA/MSS lend its support to a 50 mg/dl limit on blood alcohol content (BAC) as the maximum permissible for motor vehicle operation, and encourage the OSMA and its State Department of Legislation to lobby in support of such legislation in the State of Ohio.

(Original Resolve Clause: that the MSS lend its support to a 50 mg/dl limit on blood alcohol content (BAC) as the maximum permissible for motor vehicle operation, and encourage the OSMA and its Department of State Legislation to lobby in support of such legislation in the State of Ohio.)
MSS Assembly Action: Not Passed

Resolution 4-86

RESOLVED, that the AMA/MSS be firm in the policy that all data in resolutions will contain hard facts, figures, and quotes be referenced accordingly, or the resolution be returned to the author for additional information.
MSS Assembly Action: Passed.

Resolution 5-86

RESOLVED, that the Vice President's duties be expanded to include, under Chapter VIII, Section 3, No. 2, "Duties of the Vice President" of the MSS Bylaws: D. The Vice President is responsible for reporting and updating the Governing Council on committee chairmen and their activities.
MSS Assembly Action: Passed.

Amended Resolution 6-86

RESOLVED, that under Chapter X of the MSS Bylaws, a Section 3 be added and will read: If in fact a delegate does not meet the above responsibilities listed in Section 2, and a unanimous vote of the other Governing Council members is obtained, it will be recommended by the Governing Council, by letter to the delegate's school, documenting the specific failures of the delegate in meeting his/her specified responsibilities and recommending that the delegate be replaced by a new delegate who will represent the school, but before this is done the delegate would be formally contacted by the OSMA/MSS Governing Council to allow the delegate this opportunity to defend his/her performance at the OSMA/MSS Governing Council meeting before the vote is taken.
(Original Resolve Clause: that under Chapter X of the MSS Bylaws, a Section 3 be added and will read: If in fact a delegate does not meet the above responsibilities listed in Section 2, and a unanimous vote of the other Governing Council members is obtained, it will be recommended by the OSMA/MSS Governing Council to the delegate's school that the delegate be replaced by a new delegate who will represent the school.)
MSS Assembly Action: Passed as amended.

Amended Resolution 7-86

RESOLVED, that the OSMA/MSS again support the All-Ohio Medical School Basketball Tournament; and, be it further

RESOLVED, that the Governing Council members of the OSMA/MSS be notified of the date and place so that they may publicize the event as an OSMA sponsored activity; and be it further

RESOLVED, that an accounting report of the event be filed with the OSMA/MSS before June 1, 1986.

(Original Resolve Clause 2: that the Governing Council members of the OSMA/MSS be notified of the date and place so that they may publicize the event.)
MSS Assembly Action: Passed as amended.

Resolution 8-86

RESOLVED, that the OSMA shall actively support and participate in the development and implementation of the criteria defining impairment and the intervention into health care students' and health care providers' "substance" abuse, "drug" abuse, etc., problems; and be it further

RESOLVED, that the OSMA shall join in the pursuit of legislation protecting students impairment intervention.
MSS Assembly Action: Referred to OSMA Council.

Amended Resolution 9-86

RESOLVED, that the OSMA conduct a study to determine the feasibility and ethical considerations of a computer network, accessible to physicians, to identify persons who have filed one or more lawsuits.

(Original Resolve Clause: that the OSMA conduct a study to determine the feasibility of a computer network, accessible to physicians, to identify persons who have filed one or more lawsuits.)
MSS Assembly Action: Passed as amended.
OSMA House Action: Rejected. (OSMA Resolution 16-86)

Amended Resolution 10-86

RESOLVED, that the OSMA support efforts to provide training in the area of pediatric

emergencies and trauma to all emergency care providers, especially those involved in prehospital care, in an effort to reduce the errors in the emergency care, which have been shown to be a major contributory cause of morbidity and mortality in children.

(**Original Resolve Clause:** that the OSMA support efforts to provide training in the area of pediatric emergencies and trauma to all emergency care providers, especially those involved in prehospital care, in an effort to reduce this major cause of morbidity and mortality in children.)

MSS Assembly Action: Passed as amended.

OSMA House Action: (OSMA Resolution 22-86) This resolution was replaced by a substitute resolution and Substitute Resolution 22-86 was adopted. Substitute Resolution 22-86 reads as follows:

RESOLVED, that the Ohio State Medical Association support efforts to provide training in pediatric advanced life support and trauma for all emergency care providers, especially those involved in prehospital care.

Amended Resolution 11-86

RESOLVED, that the OSMA support early prevention, i.e., before conception, of unintended pregnancies by:

1. advocating responsible, accurate, and age appropriate sex education, particularly in public schools, and
2. promoting continuing education of up-to-date information about contraception for health care professionals, and
3. evaluating existing education programs for effectiveness.

(**Original Resolve Clause** was same omission of "evaluating existing educational programs for effectiveness.")

MSS Assembly Action: Referred to Governing Council.

Amended Resolution 12-86

RESOLVED, the OSMA/MSS shall regularly support interscholastic events for Ohio medical students which the OSMA/MSS deems as furthering the cause of organized medicine. The OSMA/MSS Governing Council must approve the sponsorship of these events.

(**Original Resolve Clause:** that Chapter XV of the Bylaws be added as follows: "The OSMA shall regularly support interscholastic events for Ohio medical students which the OSMA deems as furthering the cause of organized medicine. The OSMA/MSS Governing Council must approve the sponsorship of these events.")

MSS Assembly Action: Passed as amended.

Amended Resolution 13-86

(Considered as a Bylaws Change)

RESOLVED, that the OSMA/MSS disposable funds designated for use by the medical schools be evenly divided and dispersed to the Governing Council members at the beginning of the fiscal year, and be it further

RESOLVED, that the Governing Council members be held accountable for the use of the funds, and must submit in writing to the Vice President prior to the OSMA/MSS Annual Meeting, for inclusion in the Annual Meeting Agenda Book; and be it further

RESOLVED, that if OSMA staff decides that these funds are being misused, they may recommend to the Governing Council that the privilege be discontinued.

(**Original Resolve Clauses:**

RESOLVED, that any OSMA/MSS funds designated for use by the medical schools be evenly divided and dispersed to the Governing Council members at the beginning of the fiscal year; and be it further

RESOLVED, that the Governing Council members be held accountable for the use of the funds, and must submit in writing to the Vice President prior to the OSMA/MSS Annual Meeting, for inclusion in the Annual Meeting Agenda Book; and, be it further

RESOLVED, that if OSMA staff decides that these funds are misused, the privilege may be discontinued.)

MSS Assembly Action: Not passed.

Amended Resolution 14-86

RESOLVED, that the OSMA endorse the use of the Living Will as an advanced directive specifying the care of terminally ill patients.

(**Original Resolve Clause:** that the OSMA endorse the use of the Living Will as an advanced directive specifying the care of terminally ill patients as a legally binding document for directing the use and extent of care of a terminally ill patient.)

MSS Assembly Action: Passed as amended.

OSMA House Action: (OSMA Resolution 25-86) This resolution was amended and Amended Resolution 25-86 was adopted. It reads as follows:

RESOLVED, That the Ohio State Medical Association encourage individual members to acknowledge, when appropriate, a living will in determining the care of terminally ill patients.

Resolution 15-86

RESOLVED, that OSMA shall support and actively participate in the formation and adoption of a formal policy stating their position concerning infection of a medical student, resident, or staffed health care professional with HTLV-III, creating guidelines which justly confront the unique difficulties and conditions which such an infection produces for the afflicted individual and those he or she

comes in contact with through their position in the medical college, university, or teaching hospital.
MSS Assembly Action: Referred by OSMA/MSS Governing Council.
OSMA House Action: (OSMA Resolution 27-86) This resolution was referred to the OSMA Council.

Resolution 16-86

RESOLVED, that Chapter XI of the OSMA/MSS Bylaws be amended to include: "4. The council shall be responsible for a general review of the Bylaws of this organization every two years which shall include recommendations for additions and exclusions aimed at aligning the Bylaws with the current objectives and structure of the organization.
MSS Assembly Action: Passed.

Resolution 17-86

RESOLVED, 1) that the OSMA/MSS require each local chapter of the OSMA/MSS to submit in writing a synopsis of the intrastructure used by their chapter, in terms of organization, officers, elections, tenure, OSMA delegate selection, and interaction with school organizations; 2) that this synopsis be submitted to the OSMA/MSS Governing Council no later than 60 days prior to A-87; and be it further

RESOLVED, that the Governing Council review this information and, along with input from all interested members, make recommendations on a uniform skeleton system to be implemented by all local chapters, which may take the form of a report or resolution proposed at OSMA/MSS A-87.
MSS Assembly Action: Passed.

Amended Resolution 18-86

RESOLVED, that the OSMA/MSS Governing Council develop a list of major objectives and issues the Assembly wishes to achieve during the upcoming year, and be it further

RESOLVED, that this list, including a calendar of important dates for the organization, be sent out to all MSS Assembly members as soon as possible after institution of the new Governing Council prior to the deadline for submission of resolutions to be considered at each OSMA/MSS Annual Meeting; and be it further

RESOLVED, that members of the Assembly may make additions to the list at the annual OSMA/MSS Meeting by general consensus.

(Original Resolve Clauses:

RESOLVED, that the OSMA/MSS Governing Council develop a list of major objectives the Assembly wishes to achieve during the upcoming year; and be it further

RESOLVED, that this list be sent out to all MSS Assembly members prior to the deadline for submission of resolutions to be considered at each OSMA/MSS Annual Meeeting; and be it further

RESOLVED, that members of the Assembly may make additions to the list at the Annual OSMA/MSS Meeting by general consensus.)
MSS Assembly Action: Passed as amended.
ATTEST: *Peter D. Spatt*
OSMA/MSS Secretary

Judith Lavrich was the 1986 President of the OSMA/MSS.

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Book Review

Cervical Adenocarcinoma: A Colposcopic Atlas. By Minoru Ueki, MD, Ishiyaku EuroAmerica, Inc. Publishers

The book covers a very brief review of the history of colposcopy and the clinical value of colposcopy. It discussed briefly the techniques and the equipment of colposcopy. The New International Classification and Documentation for Adenocarcinoma were covered in detail. The author provided an in-depth guide for documenting and recording pathological findings in the cervix.

Most of the book was devoted to the excellent color plates of the atlas with accompanying descriptions and discussions of the pathologic findings.

The author covered the subject matter in great detail. He has 15 years experience in collecting his cases of pathology of the cervix using colposcopy both before and after the application of acetic acid. He cites statistics of authors from Japan, Europe and America.

This material was presented in a clear, readable fashion. The most difficult aspect was the subject matter itself, being very complex and yielding discovery only to the most astute investigator.

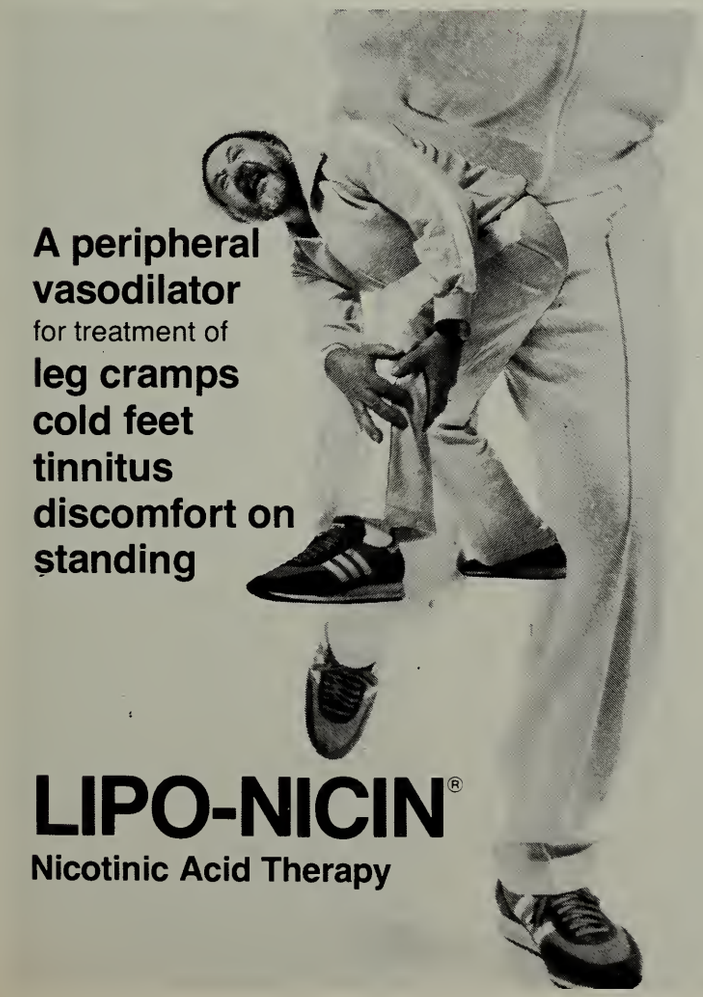
This book was extremely informative, if only from the standpoint of the rarity of the entity and, if the author's thesis is correct, the frequency with which the diagnosis is missed. From that direction the book is very useful in that it makes a good colposcopist an even better one.

The book definitely has a place in the gynecologic literature, but I feel it is not for the beginning colposcopist or even the average examiner. One reading the book without an extensive background in colposcopy will be overwhelmed by the number of details and their significance. For example, there are 13 categories of vascular pattern to recognize.

The only specialty outside gynecology which might find the book useful, interesting or even intelligible would be the pathologist with special interest in gynecologic pathology.

The language of the book definitely has a British flavour. It is difficult to follow with respect to his staging categories. However, the author is to be commended for his personal grasp of an obviously difficult subject.

John E. Holman, MD, OB-GYN and infertility and microsurgery practice, Steubenville, Ohio.



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AVAILABLE: Bottles of 100, 500.

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CLOVIS J. ALTMAIER, MD, Marion; Ohio State University College of Medicine, 1937; age 78; died June 8, 1986; member OSMA and AMA.

ALFRED BARD, MD, Cleveland; Rush Medical College, Chicago, Ill., 1937; age 78; died June 9, 1986; member OMSA and AMA.

FERRIS BEEKLEY, MD, Cincinnati; University of Cincinnati College of Medicine; 1924; age 89; died June 15, 1986; member OSMA and AMA.

JAMES J. CLEAR, MD, Coral Springs, Fla.; Univeristy of Cincinnati College of Medicine; 1943; age 67; died June 17, 1986; member OSMA and AMA.

JORDAN DENTSCHEFF, MD, Youngstown; Universitaet Wien Medizinische Fakultaet, Wien, Austria, 1950; age 62; died June 26, 1986; member OSMA and AMA.

HARRY C. ERNSTING, MD, Big Springs, Texas; University of Cincinnati College of Medicine, 1931; age 79; died June 7, 1986; member OSMA and AMA.

DONALD L. GREENAMYER, MD, Canton; Ohio State University College of Medicine, 1941; age 70; died May 9, 1986; member OSMA and AMA.

WILLIAM KATZEL, MD, Cleveland; St. Louis University School of Medicine, 1931; age 81; died June 17, 1986; member OSMA and AMA.

H. KESSLER MD, Boca Raton, Fla.; Friedrich-Wilhelms Universitaet Medizinische Fakultaet, Berlin, Germany, 1932; age 82; died April 23, 1986; member OSMA and AMA.

CLAIR KING, MD, Canton; University of Pennsylvania School of Medicine, Philadelphia, Pa., 1921; age 91; died June 14, 1986; member OSMA and AMA.

DONAL O'LEARY, MD, Columbus; National University of Ireland, 1951; age 62; died June 24, 1986; member OSMA and AMA.

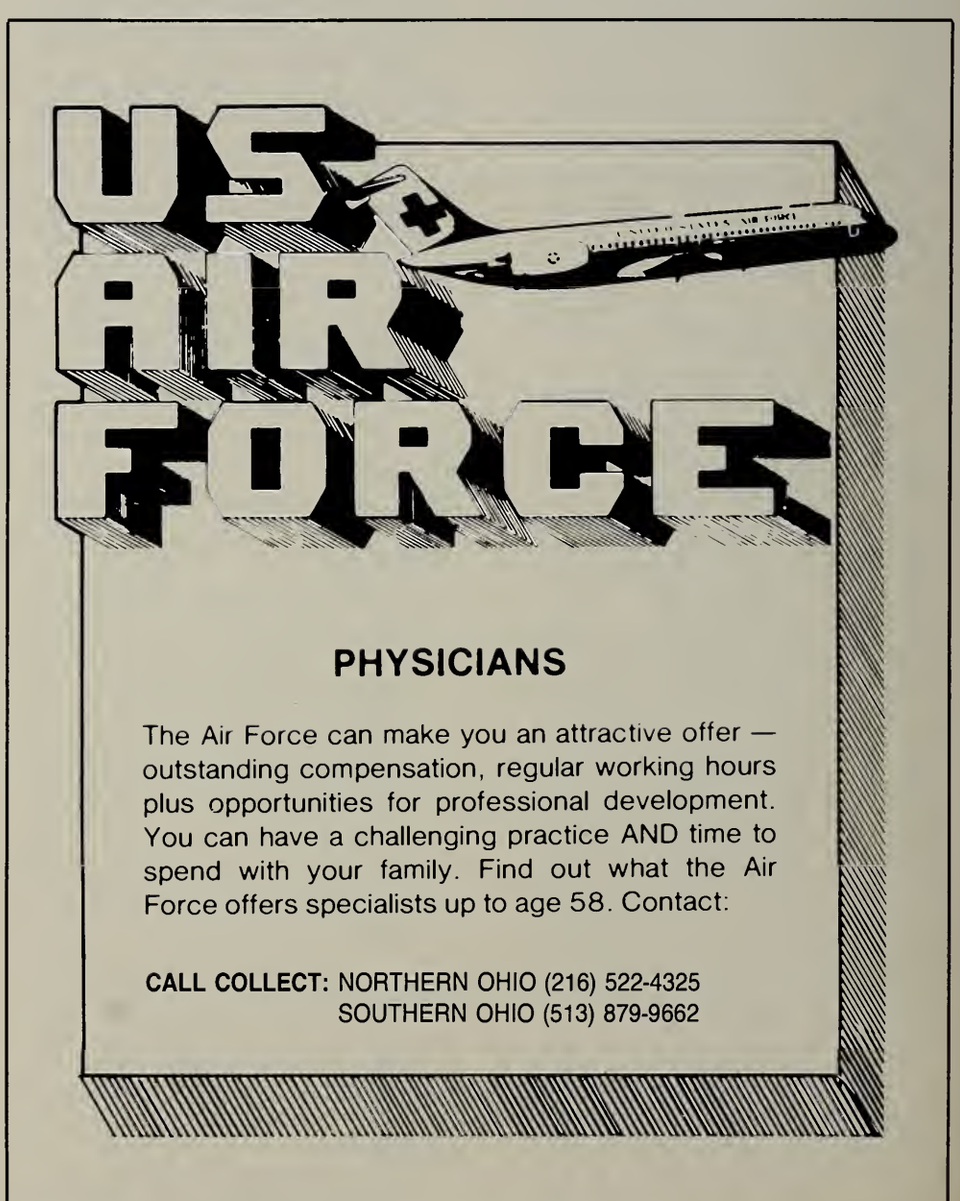
ALEXANDER P. ORFIRER, MD, Cleveland; Ohio State University College of Medicine, 1944; age 67; died June 18, 1986; member OSMA and AMA.

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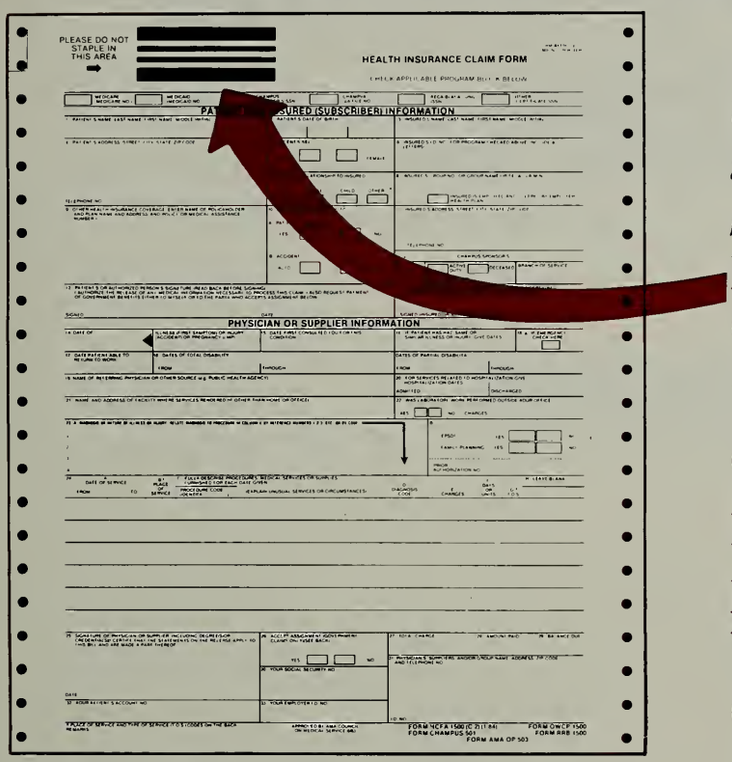
GEORGE T. RIGGS, MD, Hamilton; Washington University School of Medicine, St. Louis, Mo., 1936; age 74; died June 12, 1986; member OSMA and AMA.

BARNET R. SAKLER, MD, Cincinnati; University of Toronto Faculty of Medicine, Toronto, Ontario, Canada, 1931; age 79; died June 12, 1986; member OSMA and AMA.

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POLYCYTHEMIA VERA IN A SMALL OHIO TOWN

Gail P. Bender, MD
Donn Young, PhD
Stanley P. Balcerzak, MD

Polycythemia vera is a clonal disease of unknown etiology and low frequency. The incidence for the disease has been estimated at between 4.9 and 16 per million population per year. The present study identified 13 living patients with polycythemia vera in a town of 57,100. This represents a point prevalence for 1979 of 227.7 per million population. These findings suggest that the diagnosis of polycythemia vera is being made earlier, more accurately, and more often. However, further epidemiologic surveillance in this community may confirm this unusually high incidence rate and indicate underlying risk factors associated with the development of polycythemia vera.

Introduction

Polycythemia vera is a myeloproliferative disease of low frequency. As a result, few studies have attempted to document its incidence and prevalence. Baruch Modan reviewed hospital records from the Baltimore hospitals for the years 1951-1960 and calculated an average annual incidence rate of 4.9 ± 0.7 per million population for the Baltimore Standard Metropolitan Area.[1] Silverstein and Lanier[2] reported the Mayo Clinic experience with polycythemia vera from 1935-1969 among Rochester, Minnesota residents. They identified 19 cases of polycythemia vera over the 34-year period among a population which ranged from 25,000 in 1940 to 52,000 in 1970. They calculated an incidence rate of 1.6 per 100,000.

In 1978, we became aware of a small town in northern Ohio that had what appeared to be an unusual number of living patients who had the diagnosis of polycythemia vera. This prompted our initial investigation which was designed to identify town residents with this disorder and to document the diagnosis according to criteria standardized by the Polycythemia Vera Study Group.[3] Our investigation uncovered 13 living patients with polycythemia vera in this town of 57,100, a point prevalence of 227.7 per million.

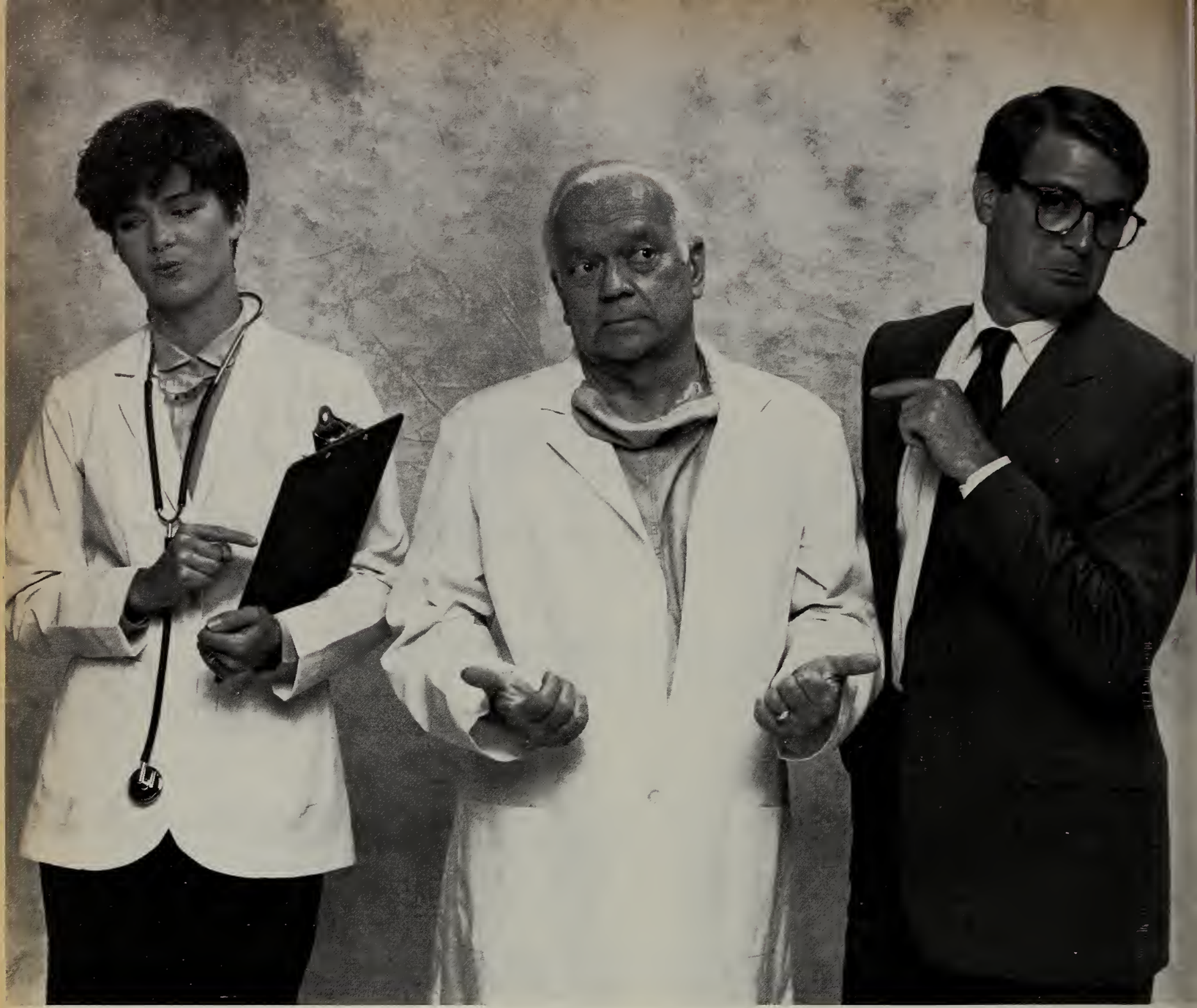
Methods

Our index case was a 64-year-old white woman who was told that she had polycythemia vera five years after her husband had developed the disease. Because she believed this an unusual event, she sought consultation with us through the Polycythemia Vera Study Group. Through her personal contacts with town residents, she had identified four people, in addition to her husband, who carried this diagnosis. This initiated the current epidemiologic study.

Our first objective was to identify all living patients in this community who had been diagnosed as having polycythemia vera or related myeloproliferative diseases. This was accomplished by contact with local physicians and by a survey of local hospital records, including in-patient charts, the blood bank's therapeutic phlebotomy file, and the laboratory record of blood volume studies.

When a patient with presumed polycythemia vera or a history of several therapeutic phlebotomies was identified, his or her medical records were reviewed to determine whether the patient

Gail P. Bender, MD, is a medical oncologist practicing in Minneapolis; Donn Young, PhD, is director of the Biostatistics and Epidemiology Unit at the Comprehensive Cancer Center, Ohio State University College of Medicine in Columbus; and Stanley P. Balcerzak, MD, is director of the Division of Hematology and Oncology, Department of Medicine, and deputy director of the Comprehensive Cancer Center, Ohio State University College of Medicine in Columbus.



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had erythrocytosis. Patients with erythrocytosis secondary to underlying causes such as cardiopulmonary disease or tumor were excluded. After informed written consent was obtained, patients thought to have polycythemia vera were asked to undergo any laboratory evaluation that had not been previously performed in order to complete the diagnostic evaluation. An unequivocal diagnosis of polycythemia vera required the patient to meet diagnostic criteria standardized by the Polycythemia Vera Study Group.[3]

Patients with definite or probable polycythemia vera were interviewed in an attempt to discover any common exposure or experiences which could suggest an underlying etiology. The questionnaire included information on residence, education, occupation, ancestry, personal and family medical history, pet exposures, diet, hobbies, religion, community activities, and blood transfusions.

In order to compare age and length of town residency of the 13 patients with those of other town residents, a control group was selected from the city's *Street and Avenue Guide.*[4] Every thirtieth household received a questionnaire requesting information on the sex, age and length of town residency for each household resident. Comparisons of the patient characteristics with those of the control population were performed using chi square goodness of fits tests and two-way analysis of variance.[5]

Results

The community involved in this study, Elyria, Ohio, is located within the commerical and industrial belt of northern Ohio. The town had a 1980 census population of 57,504, with a 1979 estimated population of 57,100. The area of the town is 19 square miles.

Table 1 lists laboratory values supporting the diagnosis of polycythemia vera in the 13 patients. Six patients (1-4, 12, 13) meet the criteria for an unequivocal diagnosis of polycythemia vera. Patients 1, 2, and 3 have polycythemia vera by major criteria. Although the oxygen saturation for patient 4 was derived from the arterial oxygen tension, his carboxyhemoglobin value was only moderately elevated at 3.2%, and his hemoglobin-oxygen dissociation curve was normal. Patients 12 and 13 did not have splenomegaly, but both fulfilled the diagnosis of polycythemia vera by minor criteria. Patient 12 had leukocytosis and thrombocytosis, while patient 13 had an elevated leukocyte alkaline phosphatase and thrombocytosis. In addition, both had normal hemoglobin-oxygen dissociation curves.

Five patients (5-9) had had red cell mass determinations done using ^{125}I-labelled albumin without ^{51}Cr-labelling of red cells. Two of these five patients (5 and 6) had hematocrits greater than 60%, a level at which almost all patients who otherwise qualify for the diagnosis will in fact have absolute erythrocytosis.[3] Patients 7, 8, and 9 not only had elevated hematocrits and red cell masses as measured by ^{125}I-labelled albumin, but also had splenomegaly, increased white counts and increased platelet counts. In addition, patients 8 and 9 had increased leukocyte alkaline phosphatase scores. Patient 9 had a normal measured oxygen saturation. Oxygen saturation for patient 7 was derived from his arterial oxygen saturation, but he had a normal carboxyhemoglobin level and a normal hemoglobin-oxygen dissociation curve. Although patient 8 had an elevated carboxyhemoglobin level, her other findings strongly support the diagnosis of polycythemia vera.

Patients 10 and 11 did not have red cell mass measurements prior to therapy. Each, however, had splenomegaly and significantly increased hematocrits, as well as elevated white platelet counts. In addition, patient 10 had an increased leukocyte alkaline phosphatase. Although the arterial oxygen saturation of patient 11 was calculated from her arterial oxygen tension, her carboxyhemoglobin level was only moderately increased at 3.8%.

The questionnaire revealed no common occupational or environmental exposure for these patients. Eleven of the 13 patients were over the age of 50 at the time of diagnosis, and all of the patients had lived in this town for at least 16 years before the diagnosis was made. The age of the patients at diagnosis was 57.3 ± 12.6 (mean ± S.D.) years, and the years of residency in this locality was 41.2 ± 17.5 years. Our control group consisted of 649 respondents with a mean age of 36.2 ± 22.8, and years of residency of 23.6 ± 18.5. When the control group was matched for age with the patient population, no difference in the length of residency in the town existed between the two groups. For the 11 patients who were diagnosed after age 50, the mean residency was 42.0 ± 20.4 years. For the 213 controls over 50 years of age, the mean residency was 40.9 ± 18.3 years.

Table 1.
Laboratory values supporting diagnosis of polycythemia vera in 13 studied patients

Patient	Sex	Age at Diagnosis	Hemoglobin[1]	Hematocrit[1]	White Blood Count[1,2]	Platelets[1,2]	Red Blood Cell Mass[3]	Oxygen Saturation[4]	Spleen Size[5]	B12[6]	Leukocyte Alkaline Phosphatase[7]	Carbon Monoxide	P50[8]
			g/dl	%	#/ul	#x10^3/ul	ml/kg	%		pg/ml		%	
1	M	57	18.7	55.3	12,200[1] 30,000[2]	603[1] 1,051[2]	59	96.8	palpable	500	183	0	25.07
2	M	78	21.1	67.7	10,600[1] 23,100[2]	293[1,2]	39.5	98.3	on L/S scan	763	329	2.3	26.68
3	M	50	21	65	14,000[1] 27,900[2]	400[1] 972[2]	43.8	98.2	10 cm	690	183	1.4	25.32
4	M	70	18.2	53.4	14,400[1] 41,500[2]	496[1,2]	45.9	95+	7 cm	780	171	3.2	23.03
5	M	55	20.4	61.2	22,000[1,2]	161[1,2]	44.4*	98.7	8 cm	365	137	2.6	26.55
6	F	56	22.2	65.9	22,000[1] 40,700[2]	148[1] 200[2]	66.3*	97.5+	12 cm	2760	130	0	ND
7	M	43	18.7	56.5	10,200[1] 12,900[2]	478[1] 805[2]	50.6*	96+	on UGI	410	67	0	23.42
8	F	51	19.2	58.2	19,500[1,2]	636[1,2]	59.7*	96.5+	3.5 cm	410	151	6.5	ND
9	M	65	17.1	52	19,900[1] 32,000[2]	400[1] 805[2]	53.4*	95	3 cm	349	250	1.6	23.08
10	F	62	19.0	56.1	10,900[1] 12,900[2]	447[1,2]	23**	95	6-8 cm	183	127	0.2	23.50
11	F	57	20.6	61.5	9,000[1] 12,500[2]	398[1] 571[2]	ND	95.7+	on IVP and L/S scan	415	88	3.8	ND
12	M	35	20.0	63	11,900[1] 17,200[2]	530[1,2]	52	93.8	undetected	280	72	1.9	24.04
13	F	71	19.4	56.4	5,300[1] 10,600[2]	231[1] 433[2]	44.3	99	undetected	460	120	1.2	25.48

[1]Blood values at presentation
[2]Highest recorded blood values
[3]*identifies RBC mass done with ^{123}I plasma volume only
[4]+denotes derived oxygen saturation
[5]Centimeters palpable below the left costal margin or splenomegaly detected radiographically
[6]Normal value 200-900 pg/ml
[7]Normal score 40-100
[8]Normal values 23-27
ND — Not done
**RBC mass done after treatment with phlebotomy & P32 at hematocrit of 48%

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Discussion

Our investigation led to the identification and documentation of 13 living patients with definite or probable polycythemia vera among a population of 57,100 people. These findings indicate that the 1979 point prevalence of polycythemia vera in this town was 227.7 per million population. Six of these 13 cases were diagnosed during the years 1977-1979. Thus, during these years, the average annual incidence for the disease was 35.0 per million. Although ten of the patients were diagnosed during the years 1971-1979, using this extended time period to calculate an average annual incidence or prevalence would have been misleading, since deceased patients were excluded from our investigation.

The present study is comparable to that performed by Silverstein and Lanier,[2] in that similar stringent criteria were required for the diagnosis. Specifically, Silverstein and Lanier required the presence of erythrocytosis and a normal oxygen saturation with any combination of splenomegaly, leukocytosis or thrombocytosis. They did not include the Category B criteria of an elevated leukocyte alkaline phosphatase score or serum B_{12} level.[3] These criteria had to be fulfilled in the absence of other conditions producing erythrocytosis. Modan's criteria were somewhat broader, in that erythrocytosis based upon hemoglobin and hematocrit values without evidence of lung disease, renal tumor or renal cyst in the presence of two of four of the criteria of splenomegaly, thrombocytosis, leukocytosis or normal oxygen saturation provided enough evidence to include the patient.[6]

Unlike the present study, both Modan and Silverstein and Lanier were limited to chart review for case finding and were unable to document the diagnosis of polycythemia vera by physical examination or diagnostic evaluation. However, the exclusion of deceased patients in the present study had the effect of reducing the time span over which the epidemiologic rates could be calculated. Furthermore, one living patient with presumed polycythemia vera was excluded from the study because of her reluctance to provide written consent for diagnostic evaluation. Our strict adherence to diagnostic criteria and our exclusion of patients unable or unwilling to undergo evaluation to confirm the diagnosis of polycythemia vera perhaps diminished the incidence and prevalence rates obtainable through chart review.

Despite these limitations, we did obtain high point prevalence and average annual incidence rates. Several explanations could account for our observations. First, the town was not selected at random. We investigated the epidemiology of polycythemia vera in this community because our index case provided unverified information about several patients who had been diagnosed as having polycythemia vera. Second, our case finding in this small community was more complete than that required by Modan. Because of the size of Elyria, we were able to personally contact most local physicians who see adult patients. Furthermore, the single hospital in this community provided the only local facility to obtain treatment with phlebotomy or P^{32}. However, because of the proximity of Elyria to Cleveland, some patients may have been missed by seeking their medical care completely outside of their town. Silverstein and Lanier were unlikely to miss patients in their case finding, due to patients leaving Rochester, Minnesota to obtain medical care elsewhere. Finally, our survey of local hospital records included review of charts with discharge diagnoses related to polycythemia vera. These discharge diagnoses included myelofibrosis with myeloid metaplasia, pancytopenia, acute leukemia, primary refractory anemia and splenomegaly. Only one patient was identified, however, as a result of this latter survey, and that was patient 4 who was identified under the discharge diagnosis of splenomegaly. The work-up done during our investigation documented polycythemia vera.

Another explanation for our observations may be that patients and physicians are now more medically sophisticated than they were during earlier surveys. Because of the increased availability of medical care to all socioeconomic groups and media distribution of public health messages, more people are encouraged to seek medical care for routine checkups as well as minor complaints. Thus, the diagnosis may have been made in patients who previously would have died of thrombotic episodes without being identified as having polycythemia vera.

Clearly, the incidence rates for polycythemia vera seem to be rising. Perhaps as our population grows older and has access to more sophisticated medical care, the diagnosis of polycythemia vera will be made earlier, more accurately, and more frequently. Alternatively, the epidemiologic data for polycythemia vera reported for this Ohio town may be too high to be attributed to a chance event or to our thoroughness. If this community demonstrates an unusual clustering of polycythemia vera, then further epidemiologic surveillance may point to risk factors associated with the development of this disease.

Summary

We investigated the incidence of polycythemia vera, a clonal disease of unknown etiology and low frequency, in a small town in northern Ohio. Thirteen living patients with the disorder were found in this town of 57,100, which represents a point prevalence of 227.7 per million. When compared with other investigations of the incidence of polycythemia vera, our results document an unusually high incidence rate. Several factors may explain the higher incidence of disease in this town; for example, earlier and more accurate diagnosis or the methods or thoroughness of our investigation. However, further epidemiologic surveillance may confirm this unusually high incidence rate and indicate risk factors associated with the development of polycythemia vera.

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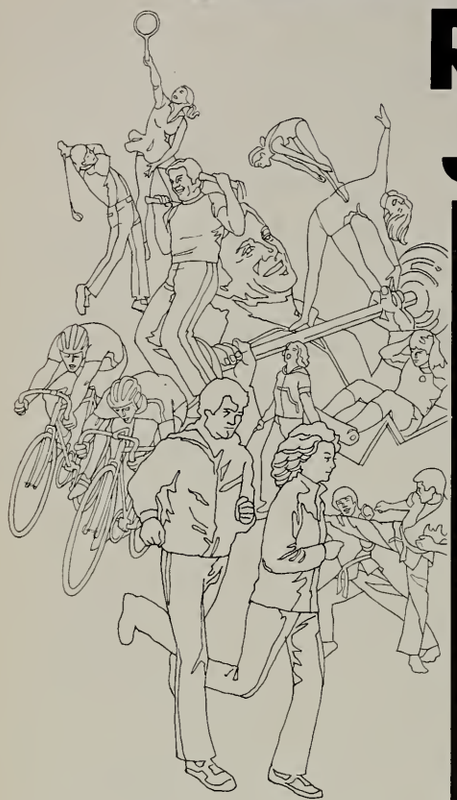
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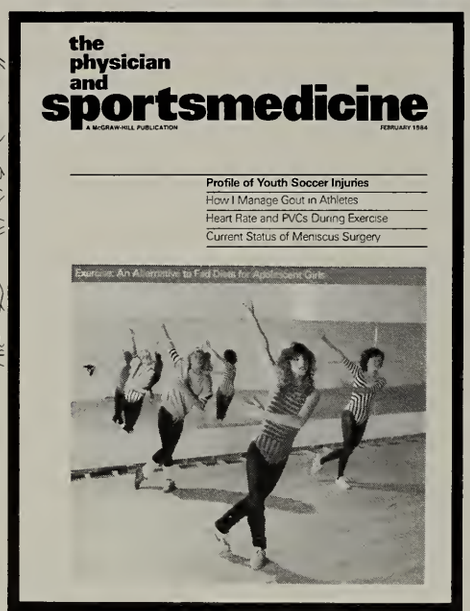
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REPAIR OF THORACOABDOMINAL AORTIC ANEURYSMS

Patrick S. Vaccaro, MD
Elmahdi Elkhammas, MD
William L. Smead, MD

Thoracoabdominal aortic aneurysms are rare lesions that are generally amenable to operative treatment. Unfortunately many patients succumb to their lesions because many physicians still consider them inoperable. The diagnosis should be confirmed by angiography when possible. Renal failure and paraplegia are the most serious postoperative complications, but excellent perioperative survival can be obtained and long-term survival is achievable. Seventeen elective and five emergency procedures have been performed with survival of 88% and 60% respectively.

Thoracoabdominal aortic aneurysms are rare and are often incorrectly thought to be untreatable owing to their extensive nature. The surgeon operating upon such lesions must be prepared to replace long segments of the thoracic and abdominal aorta with expedient reestablishment of visceral circulation. Most worrisome is the development of paraplegia following an otherwise successful operation.

Ellis and associates[1] were the first to show that such aneurysms were operable. In 1954, they replaced an abdominal aortic aneurysm that involved the right renal artery by inserting an aortic homograft with an arterial homograft bypass to the renal artery. In the same year, Etheridge and associates[2] successfully replaced a suprarenal aortic aneurysm involving the iliac and superior mesenteric arteries. The aneurysm was excised while the area was temporarily bypassed by a polyethylene tube and replaced by an aortic homograft. In 1955, DeBakey and associates[3] expanded the scope of the operation by replacing an extensive thoracoabdominal aortic aneurysm with a homograft. Later this same group introduced the technique of permanent bypass with a Dacron prosthesis. Such operations were lengthy, required as many as 15 separate anastomoses, and mortality was 26% (Fig. 1).

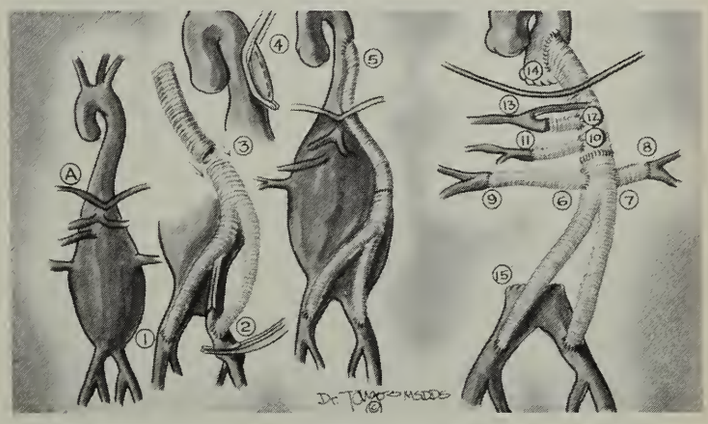


Figure 1.
Operation as described by DeBakey and associates. Note as many as 15 separate anastomoses are necessary. Numbers 8 and 9 show anastomoses to left and right renal arteries, while 11 and 13 are to the superior mesenteric and iliac arteries.

From the Division of Vascular Surgery, Department of Surgery, The Ohio State University College of Medicine, Columbus.

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In 1965, Crawford[5,6] revolutionized the treatment of thoracoabdominal aortic aneurysms by incorporating three well established technical principles used in other situations. First, the graft inclusion technique reported by Javid[7] in the treatment of infrarenal abdominal aortic aneurysms was applied. Second, an attempt was made to minimize the incidence of paraplegia by reattachment of the intercostal and lumbar arteries to the graft in the manner described by Spencer[8] in animal studies. Third, visceral artery attachment was performed by the simple suturing of openings made in the graft circumferentially around the uninvolved origins of these vessels as described by Carrel.[9]

Since 1980, 22 patients have been operated upon for thoracoabdominal aortic aneurysms on the vascular service at The Ohio State University Hospital. The first three patients were operated upon using the multiple bypass technique of DeBakey, while the remaining 19 patients were operated upon in the fashion described by Crawford.

Methods

Sixteen men and six women ranging in age from 50 to 78 years (average 66 years) underwent operation. Seventeen operations were performed electively, while five were performed on an emergency basis for rupture. All of the patients undergoing elective operation and three of the patients having emergency operations had preoperative aortography. Nineteen lesions appeared fusiform atherosclerotic in nature, while two aneurysms were secondary to dissections starting in the descending thoracic aorta. Patients were classified according to the extent of aortic involvement. In Group I, the aneurysm involved most of the descending thoracic and upper abdominal aorta (three patients). In Group II, most of the descending and abdominal aorta was included (six patients). Group III patients had involvement of the distal descending and abdominal aorta (seven patients). Finally, in Group IV, only the abdominal aorta was involved (six patients).

Hypertension affected 50% of patients and was controllable. Forty percent of patients had significant cardiac disease manifested by previous myocardial infarction, left ventricular dysfunction, or angina pectoris. Stroke and chronic obstructive pulmonary disease each had affected 14%.

Surgical Technique

Operative exposure is obtained through a thoracoabdominal incision either through the sixth or ninth intercostal space, depending on the proximal extent of exposure required. The incision is carried over to the midline either above or below the umbilicus and continued down to the pubis. The abdominal aorta is exposed extraperitoneally, and the viscera including the left kidney mobilized anteriorly. The thoracic and abdominal cavities are allowed to communicate by radially splitting the diaphragm down to the aortic hiatus. The proximal aortic clamp is applied above the lesion without the use of heparin, shunts or bypass. The distal aorta or iliac vessels are similarly crossclamped, and the entire aneurysm is opened posterolaterally. Bleeding from the celiac and superior mesenteric arteries is controlled by the insertion of #4 Fogarty catheters. Bleeding from the renal arteries is controlled with Pruitt irrigation-occlusion catheters. This permits cooling of the kidneys by perfusion of each with 500 cc. Ringer's lactate at 4°C. Bleeding intercostal and lumbar arteries are oversewn from within the aneurysm sac unless they are to be reimplanted into the graft. Arteries chosen for reimplantation are usually large and exhibit poor back bleeding, suggesting poor spinal cord arterial collateralization in that area.

A woven Dacron graft of appropriate size is sutured end-to-end to the proximal aorta with 000 polypropylene. If any intercostal vessels are to be reimplanted, the graft is placed under tension and an oval opening made in the graft opposite the intercostal vessel orifice. A circumferential anastomosis is performed around this orifice with continuous suture (Fig. 2). The visceral

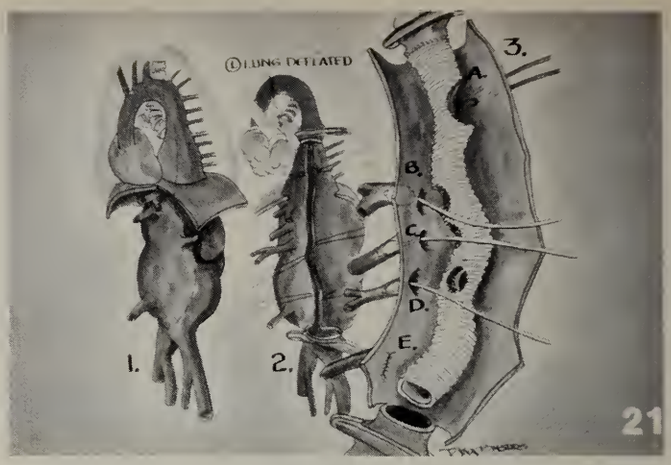


Figure 2.
Operation as described by Crawford. 1: exposure of aneurysm; 2: direct crossclamping of aorta and posterolateral opening; 3: inclusion technique for grafting: A. intercostal arteries; B. celiac artery; C. superior mesenteric artery; D. renal arteries; E. suture closure of inferior mesenteric artery. Balloon catheters are in place to prevent backbleeding.

vessels are reattached to the graft in a similar fashion with the number of openings in the graft varying from one to four, depending upon the distance between the visceral orifices (Fig. 3). The graft is then appropriately flushed by temporary release of the proximal aortic clamp. A clamp is then applied across the graft below the renal artery reattachment, and flow is restored to the visceral arteries by deflation and removal of the occluding catheters. The distal anastomosis is then performed at the appropriate level distal to the aneurysmal or occlusive disease. The aneurysm wall is then sutured over the graft and the incision closed in standard fashion with tube drainage of the left pleural cavity.

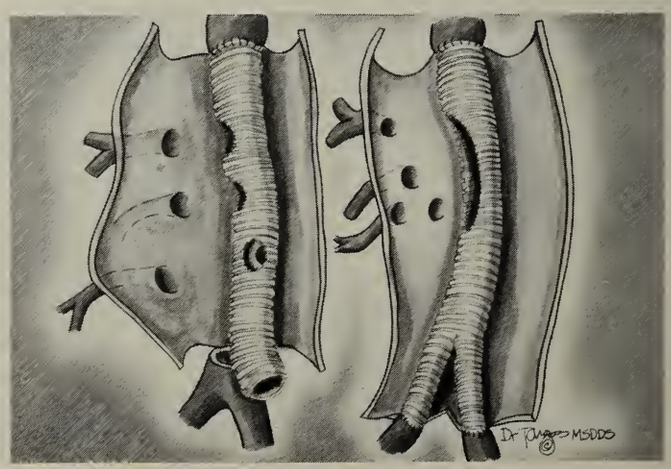


Figure 3.
Techniques available for reimplantation of visceral arterial orifices into graft depending upon distance between vessel orifices.

Results

Fifteen of 17 patients (88%) undergoing elective operations and three of five patients (60%) undergoing emergency operations survived the perioperative period. Deaths after elective procedures occurred early in the experience, and the last 10 procedures have been performed without mortality. The two deaths

in the patients undergoing emergency operations were caused by massive visceral infarction which was noted at the time of operation in one, and irreversible renal failure and pulmonary sepsis in the other. Both deaths in patients operated upon electively resulted from postoperative hemorrhage. In one, this was due to an unrecognized injury to the right renal artery leading to multisystem organ failure, and in the other to uncontrollable hypothermia.

Pulmonary complications affected 42% and were the leading cause of postoperative morbidity. Three patients with preoperative COPD required prolonged ventilatory support, and all survived. Four patients developed persistent atelectasis with effusions, and two patients suffered pneumonia. Renal insufficiency requiring dialysis occurred in two elective cases (12%) and two emergency cases (40%). One patient from each group died and the other totally recovered. Paraplegia developed in three patients (14%), but was complete in only one. One patient with mild anterior spinal cord syndrome completely recovered in three weeks, and the other walks with the support of a cane. Two patients required embolectomy of the leg in the immediate postoperative period, with prompt reestablishment of circulation.

There were four late deaths at three, six, seven, and 16 months following operation, and all were caused by myocardial infarction. The remaining 18 patients are alive from two to 60 months after operation, including six patients who have lived at least three years.

Discussion

Thoracoabdominal aortic aneurysms can be operated upon successfully. Crawford and associates[10] recently reported survival in excess of 90% in over 500 patients. Our survival of 88% and 60% in the groups operated upon electively and as emergencies compares very favorably. Unfortunately, however, owing to the misconception of many physicians that these lesions are too extensive to be corrected, patients continue to succumb to unnecessary rupture of the aneurysm. Such lesions are just as dangerous as infrarenal aortic aneurysms and an aggressive approach to treatment is indicated.

Thoracoabdominal involvement of the aorta by aneurysmal disease should be suspected if, on physical examination, the physician palpates aneurysmal changes in the abdominal aorta that are so extensive that the cephalad projection of the aneurysm is obscured to palpation by the costal margins of the thoracic cage. In such cases, plain chest roentgenograms may show aneurysmal dilatation of the descending thoracic aorta. Similarly, flat plate films of the abdomen may show aneurysmal calcification in the upper abdomen. Any of these findings are strong indications of a thoracoabdominal aortic aneurysm and should lead to the performance of appropriate angiography in patients deemed suitable for operative intervention. In patients in whom angiography is unsafe because of renal insufficiency, thoracic and abdominal computerized axial tomography may be substituted.

Currently, operation is offered to all patients unless they appear terminally ill with cardiac, pulmonary, renal, or neoplastic disorders. All symptomatic patients are offered operation, regardless of risk factors. It is imperative that a cohesive operating team be established if excellent results are to be achieved. The anesthesiologist, surgeons and nurses must work in concert to reduce operating time and human error. Such operations should not be performed in institutions where only occasional vascular surgery is performed or in those ill equipped in critical care technology. No amount of critical care sophistication, however, can salvage an ill-conceived and poorly performed operation.

Paraplegia remains a significant concern and its prevention is not clear. Crawford reported an overall incidence of 11%, with occurrence two and one-half times greater in patients in Group II. Occurrence was rare when only the abdominal aorta was involved. In our experience, paraplegia occurred in one patient in Group I and two patients in Group II. However, the number of our patients was too small to determine statistical significance.

Clinically significant renal function disturbances occurred

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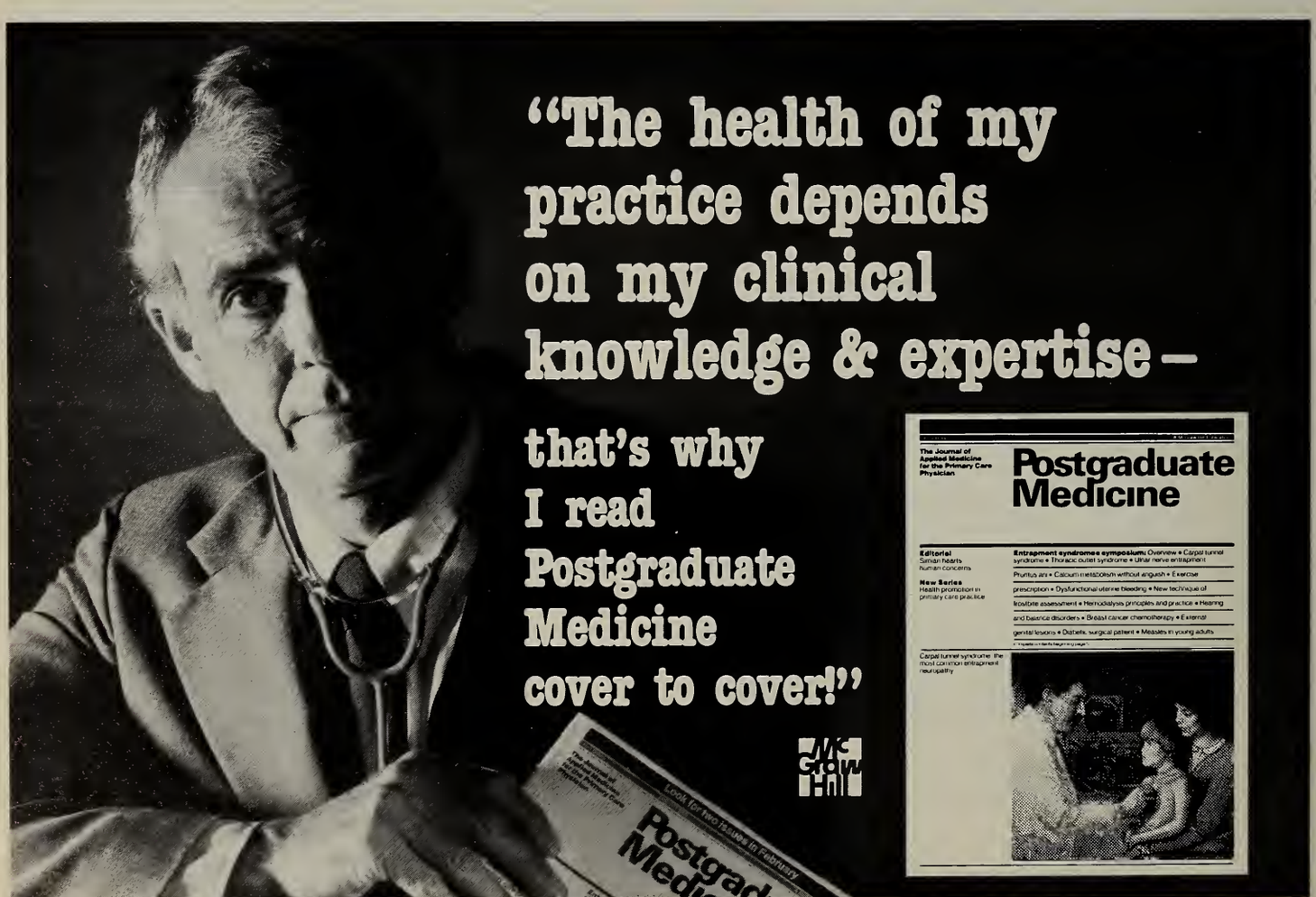
in 12% of patients undergoing elective operation. Attempts to reduce renal dysfunction consisted of selective hypothermia of the kidneys by direct infusion of cold Ringer's lactate and minimization of suprarenal crossclamping. Suprarenal clamp time varied from 20 to 78 minutes, but averaged 47 minutes. However, in this series, there was no correlation between the clamp time and the development of renal impairment.

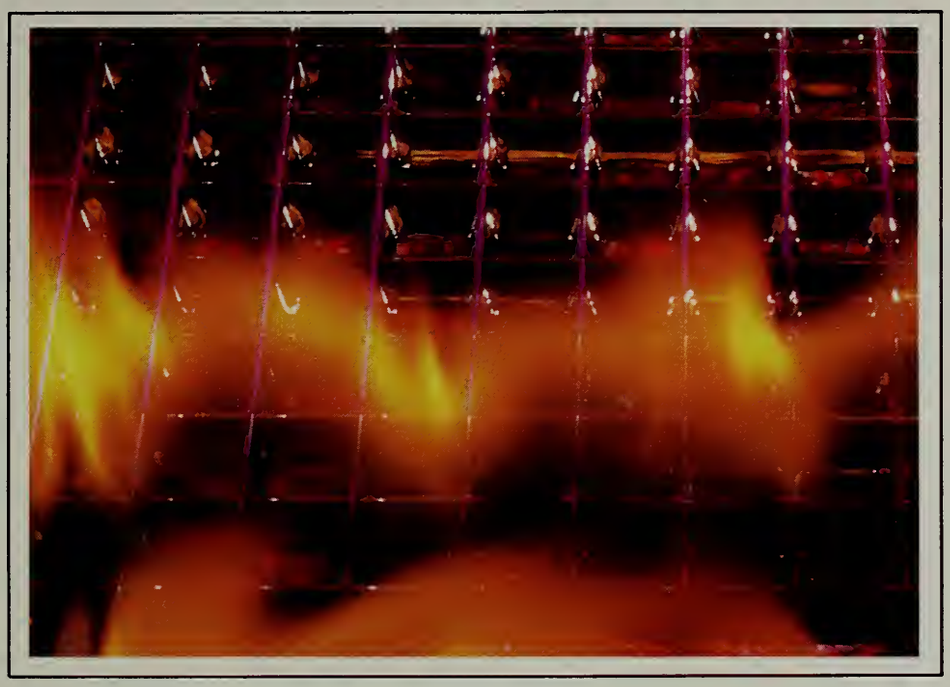
Summary

In general, patients with thoracoabdominal aortic aneurysms can be treated successfully. Increased awareness by physicians that operative correction is available should result in a lower incidence of death from rupture. Elective and emergency operations at our hospital have resulted in 88% and 60% survival respectively. Although pulmonary involvement (42%) remains the most frequent postoperative source of morbidity, renal insufficiency (12%) and paraplegia (14%) remain the most serious, but in many cases are reversible. A team approach in the treatment of these lesions is necessary if successful results are to be achieved.

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The Malpractice Crisis: A National Perspective

By Karen S. Edwards

During the 1970s, as the steep wave of professional liability claims came crashing down around the insurance industry, it was easy to believe that a crisis was in the making.

After all, at that time, many physicians suddenly found themselves bare of liability coverage as insurance companies, scrambling to stay afloat in the deluge of claims that were filed after 1972, began to lose ground. Many simply went out of business, others withdrew their liability coverage. Those that remained raised their rates. So, when the '70s "crisis of availability" is mentioned, people knowingly nod their heads, content in the belief that a crisis has come — and, thankfully, gone.

Now, however, the nation buzzes with a new crisis — an " '80s crisis" — a "crisis of affordability." How *real* is it? The only way to tell is to step back and take a long-range view of the problem.

In June of 1984, the American Medical Association (AMA) decided to do just that, as its House of Delegates voted to create a Special Task Force on Professional Liability and Insurance to study the liability climate. In October of that year, the Task Force issued its first report. It was far from reassuring.

"A look at what has been happening with regard to numbers and costs of claims reveals that the professional liability problem is again extremely serious — and that actually, in some areas of the nation, from a financial impact standpoint, it is more serious than it was in the mid-'70s. The temporary respite that followed the mid-'70s upheaval is over."

Using statistics gathered by the AMA Task Force from commercial, physician-owned and independent insurance companies as a base point, there is little doubt that the "crisis of affordability" is not only very real, but is sitting right there on physicians' doorsteps.

Claims Against Physicians Increase

Perhaps the most alarming statistics gathered by the Task Force are in the area of claims increases. During the "crisis year" of 1975-76, when insurance companies were literally drowning in claims, a total of 14,074 claims against physicians and surgeons were filed. Yet, in 1983, even modest projections indicated that

One out of every five Class I physicians can expect a claim. If you're a higher risk, expect your chances to double.



the total number of claims ranged about 40,000.

That means that physicians' chances of having a claim or suit filed against them has increased tremendously. By how much? That, of course, depends on your classification. One out of every five Class I physicians can expect a claim. If you're in a higher-risk classification, expect your risks to double. In mid-1984, for example, the American College of Obstetricians and Gynecologists reported that 60 percent of all OB-Gyns in the nation have been sued (20 percent of *them* three times or more) — and figures from St. Paul Insurance Companies, one of the largest liability carriers, recently concluded that OBs can expect at least eight claims during a typical 35-year career. (Compare that to only two claims which are generally filed against family physicians during that same time frame.)

But OBs aren't the only ones facing greater risks. Surgeons — general, orthopedic and neurosurgeons — are just as much at risk, generating a percentage of claims which is far out of proportion to their numbers in the insured population. They generate an average 34.5 percent of all claims, despite the fact that they make up only 19 percent of all policyholders.

What seems most amazing about this claims increase is that it appears to be a rationed phenomenon. Risks are just as great for the rural or small-town physician as they are for urban practitioners.

Timothy Graham, actuarial services officer in the medical services division of the St. Paul Insurance Companies, noted in the AMA Task Force's 1984 report that: "The trend is countrywide; we can't say there are any regional hotbeds. Generally, we're finding that there is no distinction between rural and urban areas anymore. It's fading."

Hospitals, too, are registering larger claims increases — so the physician is not alone.

Settlements Increase

Adding fuel to this raging fire is the amount of money which is now being paid out to settle these claims.

In 1975, the average medical malpractice verdict was $171,019, excluding million dollar verdicts, and $220,018 including million dollar verdicts. Those figures increased significantly in following years: in 1980, $260,989, excluding million dollar verdicts, and $404,726 including million dollar verdicts; and in 1985, $215,092 and $1,017,716, respectively (Jury Verdict Research, Solon, Ohio).

The latest figures available show that there have been 196 million-dollar verdicts in medical cases — three in 1975, 10 in 1980 and 45 in 1982. One ACOG spokesman said in the Task Force report that: "Now there are more than four million-dollar verdicts in personal injury cases per week." And some cynics now say the day isn't far away when $2 million suits will be regularly filed against physicians.

There is no question that the severity of these award settlements has taken a heavy toll. In Florida, for example, two or three astronomical settlements awarded during 1983 bankrupted that state's Patient Compensation Fund; and in Wisconsin, *that* state's Patient Compensation Fund is projecting a 1985 deficit of $48 million.

Why this trend toward sizeable awards? No one seems to have a ready answer. A recently released report by the Rand Corporation notes that: "Jurors (seem) even more sympathetic to plaintiffs

The AMA Task Force found that the total premiums paid by physicians have increased, on the average, about 17 percent.

injured by medical malpractice. Observed malpractice awards were large (five times those in injury-on-property cases), but not apparently because plaintiffs claimed particularly severe injuries. In fact, the differences between malpractice and other awards were not reduced when we adjusted for injuries. Rather, our analyses suggested that among plaintiffs with the same injury, a malpractice plaintiff received an award five times the size of an award to an injury-on-property plaintiff and almost twice as large as the award to a work injury or product liability plaintiff."

The tragic news is that, despite hefty award settlements, the injured patient customarily receives less than 30 cents of the insurance premium dollar. Lawyers and litigation costs consume the rest. And, if all goes well, the patient can expect to get his or her share in about four years — the average length of time it takes for a lawsuit to be decided.

Rates Increase

Like the 1970s crisis, these increasing number of claims and the severity of these claims are eating into the reserves of every professional liability company from Maine to California. As a result, liability companies are doing the only thing they can do — short of folding their businesses the way some were forced to do during the 1970s. That is, they are raising their rates — higher and higher, and, in some cases, to astronomical proportions.

For example, there are some New York City neurosurgeons paying as much as $100,000 a year in premiums; Detroit orthopedic surgeons are paying $68,000; while across the rest of the country, premiums of $50,000 — once thought to be outrageous — are now quite common.

The AMA Task Force found that the total premiums paid by physicians have increased from $1.43 billion-$1.47 billion in 1982 to $1.65 billion-$1.75 billion in 1983 — an increase of about 17 percent. But that's an average increase. If you factor in retroactive increases and the huge increases made in the premiums of some high-risk specialties, as well as increases brought about by recent hospital requirements mandating staff physicians to carry $1 million liability coverage, then one gets a better idea of the *true* dimensions of this latest malpractice crisis.

The trouble is, these dimensions can vary greatly — from state to state and from specialty to specialty. The hardest-hit specialties seem to be OB-Gyn, orthopedic and neurosurgery. A closer look at each of these different "trouble zones" provides a better picture of the "crisis of affordability" and how it is affecting the nation.

Who Will Deliver the Babies?

There is no question in anyone's mind that obstetricians and those providing obstetrical care are paying higher liability rates (on the average, OBs pay the highest rates of any doctor). To get an idea of just how high those rates are, take the example of one North Carolina family physician who also delivers babies. This particular doctor watched his premiums rise from a rate of $20,694 in 1984 to $124,434 in 1986. Needless to say, he dropped his obstetrical practice, and he wasn't the only one in the state to do so. According to recent surveys, half of all family practitioners in the state of North Carolina who still deliver babies have dropped the obstetrical part of the practice (and a quarter of the baby-delivering f.p.s in California have done the same). And, in Yale, Michigan, one community hospital had to recently shut down its obstetrical ward when the family practitioners in town stopped providing obstetrical care.

But what if your entire practice *is* obstetrics?

According to a survey taken last November by ACOG, over 12 percent of their members report they will no longer deliver babies, although again, that varies from region to region. In Florida, for example, where premiums for OBs are reported to run as high as $125,000, 25 percent of the obstetricians in that state do not deliver babies, and 30 percent are considering stopping. In Massachusetts, 20 percent of the OBs are not taking new patients; and, in California, one-quarter of the OBs who responded to a recent survey have stopped delivering babies; 32 percent have considered stopping; and 46 percent — almost half — have reduced their "high-risk" caseload. In addition, 43 percent of the California obstetricians are deciding on either an early retirement or a specialty shift.

Probably the worst case is in upstate New York, where, in Syracuse, 85-90 percent of the OBs there will not deliver babies.

"I'll tell you why I quit after 10 years of delivering babies," says Dr. David A. Ronk, of Norman, Oklahoma, in an article which appeared in the *New York Times*. "It just got to be too much hassle for the return. It's not just the disruption of your life 24 hours a day. It's a whole atmosphere of confrontation now between doctors and patients. We believe someone must always be at fault. We're suing car makers. Why not baby makers?"

"We're trained to deal with medical and social problems, not legal and business problems."



"When you deliver a baby today," agrees Dr. Theodore Loring in the same article, "parents expect it to come out perfectly. Unfortunately, it doesn't always turn out that way. Twenty years ago, it was considered an act of God. Today, there are no acts of God. They expect you should have been able to do something."

It is this type of high patient expectation that is doing as much as the liability premiums to drive OBs out of the marketplace. Nationally, 73 percent of the respondents to the ACOG survey indicated that they had been sued at least once by parents expecting miracles.

"None of us were trained to deal with this type of adversity," says Wayne Lippert, MD, president of the Cincinnati Obstetrical and Gynecological Society in the same *N.Y. Times* article. "We're trained to deal with medical and social problems, not legal and business problems. Unfortunately, it's getting so that the legal and business problems sometimes interfere with or govern the medical care."

The Buffalo Crisis

The predicament that took place early last summer in Buffalo, New York, paints a "worst scenario" picture of the 1980s "crisis of affordability" — but one that accurately reflects the nation's present liability climate.

According to an article in *Physician's Management,* 1985 began on the wrong foot in New York state, with the insurance commissioner approving a 55 percent premium rate increase, and no sign coming from the statehouse that doctors' liability would be limited to $1 million, *or* that a cap of $250,000 would be placed on pain and suffering awards.

So, the high-risk doctors in this upstate New York city began to slow down their practices. By late May, all orthopedic surgeons, all neurosurgeons, all but one GS, and all but three OB-Gyns either stopped practicing or refused to take new patients. The effect was alarming. Hospitals closed beds and staff was laid off. By July, the state health commissioner threatened to prosecute any doctor who refused to treat patients. So, the doctors returned to work, accomplishing little, other than uniting the community in their favor. To their chagrin, however, the doctors had not gained the support of their big-city colleagues in Manhattan, nor had they raised much interest at the statehouse. It was, in essence, an experiment that didn't work, but it does serve to illustrate the extent the "crisis of affordability" is pushing those in the medical profession, and especially those in the high-risk specialties.

Like the obstetricians, orthopedic surgeons are also finding the liability climate far from favorable. In Massachusetts, one orthopedic surgeon learned that his 1986 liability premium was going to be $26,900, with a retroactive bill of $31,000 on the way. The surgeon decided to restrict his practice to office work only — thereby dropping the rate of his premium to only $4,000.

Neurosurgeons are adopting the same line of defense, eliminating surgery from their practices and limiting themselves to neurology. One upstate New York neurosurgeon saw his premium drop from $60,000 to $28,000 as a result.

The "Crisis of Affordability's" Bottom Line

What the "crisis of affordability" is doing then — the bottom line — is driving physicians out of practice.

What the "crisis of affordability" is doing then — the bottom line — is driving physicians out of practice.

Surgeons are giving up surgery; experienced obstetricians — the ones best suited for high-risk deliveries — are retiring in their early sixties; and young obstetricians are abandoning their practices for lower profile work in insurance companies and pharmaceutical firms. Aspiring physicians and medical students are being discouraged, both from the high-risk specialties of medicine, and from the practice of medicine itself.

Right now, there doesn't appear to be an end in sight. The report by the AMA Task Force found insurance companies doubtful that rate hikes will be reduced in the near future.

"The price of the product continues to spiral upward. There's no way of knowing when or by how much because we take it state by state and on a monthly basis. Who knows? Depending on the class and states, rates could increase in the teens range — or all the way up to 100 percent," says one Medical Protective spokesman in the AMA's report.

The problem, as the report points out, is that even with the constant upward march of premiums, insurers seem to be fighting a losing battle against losses. With loss ratios of 140 to 150 percent of premiums collected as they were in 1982, "this business is no success, claims made or otherwise, professionally sponsored insurer or otherwise," says Best's Insurance Management Reports.

Does that mean the "crisis of affordability" will eventually lead back to one of "availability"? Only time can answer that.

In the meantime, however, claims continue to increase, awards continue to increase, and rates continue to increase — a vicious chain that no one has been able to break. Yet everyone suffers from the result.

The Cost

Certainly the insurance companies suffer, as they see their successful operations taking loss after loss; the patients suffer as more and more physicians leave practice — thereby reducing not only the availability, but the quality of health care; the public-at-large suffers as "defensive medicine" places a higher and higher price tag on medical care; and, of course, the physician suffers — financially, because of higher premiums, but not necessarily because of the lawsuit itself.

Although physicians *can* be risking all of their personal worth with every claim brought against them, the fact is that fully 75 percent of all claims are closed with no indemnity or payment, and, in those cases that *do* go to trial, physician defendants continue to prevail in 70 percent of the cases.

But their victories have cost them, too — financially, emotionally, and in time. As one obstetrician recently put it: "You may have documentation to defend yourself, but you still go through hell for one, two, three years of depositions and hearings. And you may win. But by then, you've already lost." **OSMA**

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BOARD CERTIFIED INTERNIST-CARDIOLOGIST, Ohio and Kentucky licenses, seeks emergency room Cincinnati, Northern Kentucky. Reply to Box No. 98, c/o Ohio State Medical Association, 600 S. High St., Columbus, OH 43215.

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CHAIRMAN, DEPARTMENT OF SURGERY — Fairview General Hospital, progressive 475-bed community hospital with five-year general surgery residency program, seeks Chairman for Department of Surgery. All surgical specialties represented including open heart. Construction beginning soon on new surgical facilities. Ideal candidate possesses leadership abilities, strong interpersonal skills, administrative talents, and teaching experience within a residency program. Send curriculum vitae to Jack Bell, Administration, Fairview General Hospital, 18101 Lorain Avenue, Cleveland, OH 44111.

CINCINNATI, OHIO: Seeking director, full-time and part-time physicians for new walk-in clinic based in affluent northeastern suburban community. Attractive hours, competitive salary with incentive and malpractice insurance provided. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Rm. 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

DIRECTOR. Progressive physician group seeks Medical Director for a new ambulatory care center in Chagrin Valley area. Applicant responsible for establishing Center protocols, physician staff supervision, marketing and public relations involvement. Qualifications: MD or DO with Family Practice and/or Emergency Medicine experience. ACLS, innovative, flexible, possess demonstrated interpersonal skills and success in program development and administration. Competitive salary commensurate with experience. Send resume and salary requirements to: Richard Ostendorf, MD, Box 39551, Solon, Ohio 44139.

FAMILY PRACTICE — Northern Ohio Family Physician Group seeking additional member. Immediate opening. Guarantee and fringe benefits. Send CV to Reply Box 105, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, OH 43215.

GENERAL AND FAMILY PRACTICE PHYSICIAN NEEDED for small western Ohio town. Salary plus fringes. May have a sub-specialty. Prefer mature physician. Send resume with references to Ohio State Medical Journal, PO Box 104, 600 S. High Street, Columbus, OH 43215.

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ACTIVE MEDICAL PRACTICE FOR SALE: Practitioner retiring. Ideal for family practice or internist, solo or group. Inquiries PO Box 8144, Hyde Park, Cincinnati, OH 45208.

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FOR SALE: Established ENT practice. Board certified or eligible otolaryngologist. Northeastern Ohio. Send resume to PO Box 102, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, OH 43215.

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Editor's note

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that other words are defined. Of course, the definition must be consensually derived, he says, using the input and perspectives of payors, providers (both hospital and medical), and consumers. And once arrived at, the definition is changeable — as evolutionary as the societies and times through which it travels. To help with this definition, Dr. May has outlined certain criteria — what he refers to as "The Five A's of Health Care System Quality," which he hopes will serve as a starting point for discussions on the subject of quality health care. His article expands on these criteria — as well as his idea for a consensus-derived systemic definition of quality in health care.

References:

1. May, A.N., "The Five A's of Health Care Quality Proposed as Guidelines for Standards, FAHS Review, Vol. 19, No. 3, May-June, 1986.
2. May, A.N. "Strategies in Health Care Cost Reduction." Physician Executive, Vol. 12, No. 3, May-June, 1986.

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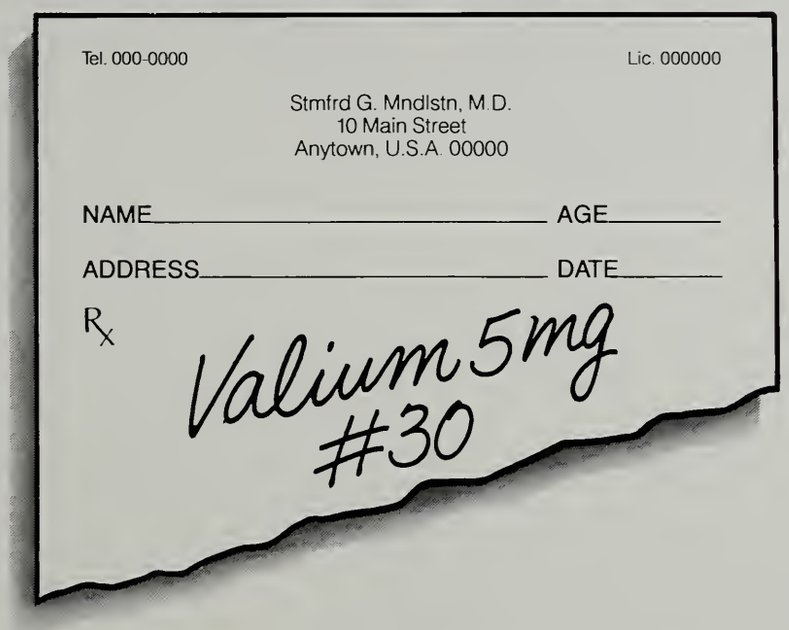
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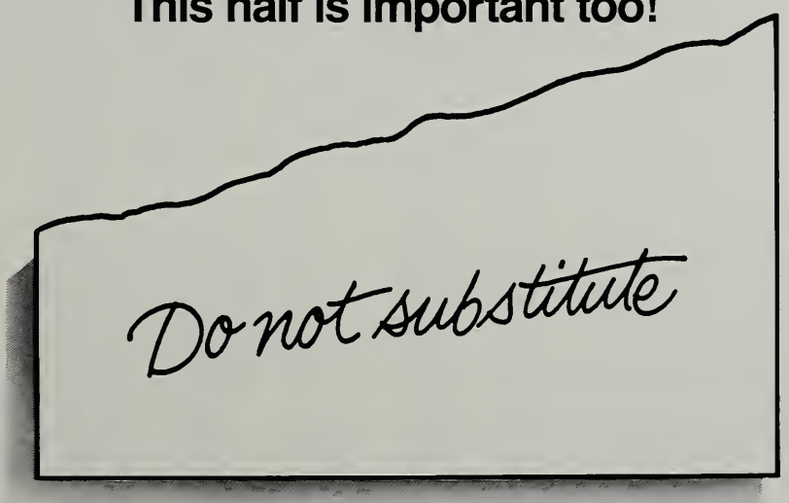
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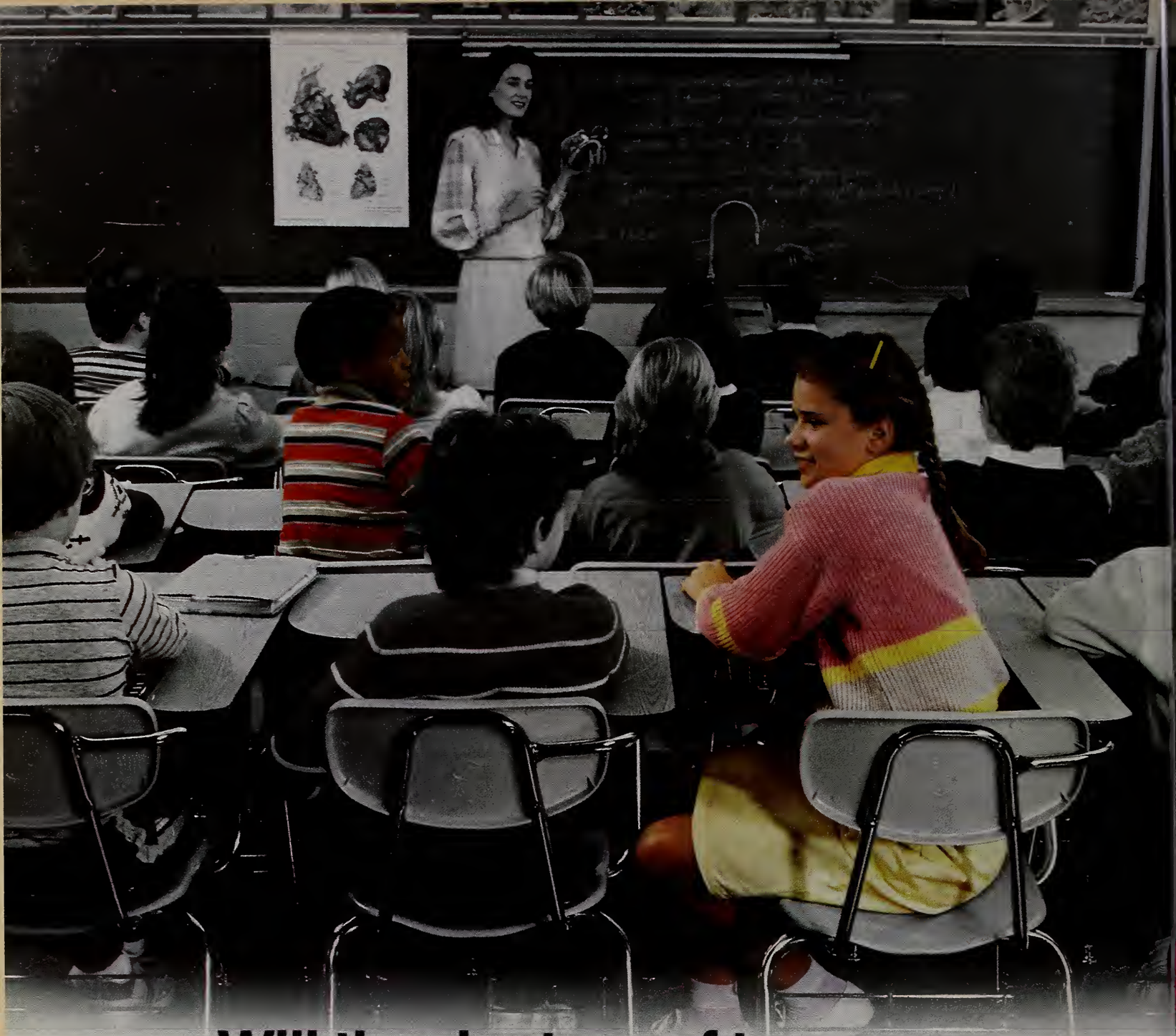


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THE Ohio STATE Medical Journal

VOL. 82, NO. 10, OCTOBER 1986

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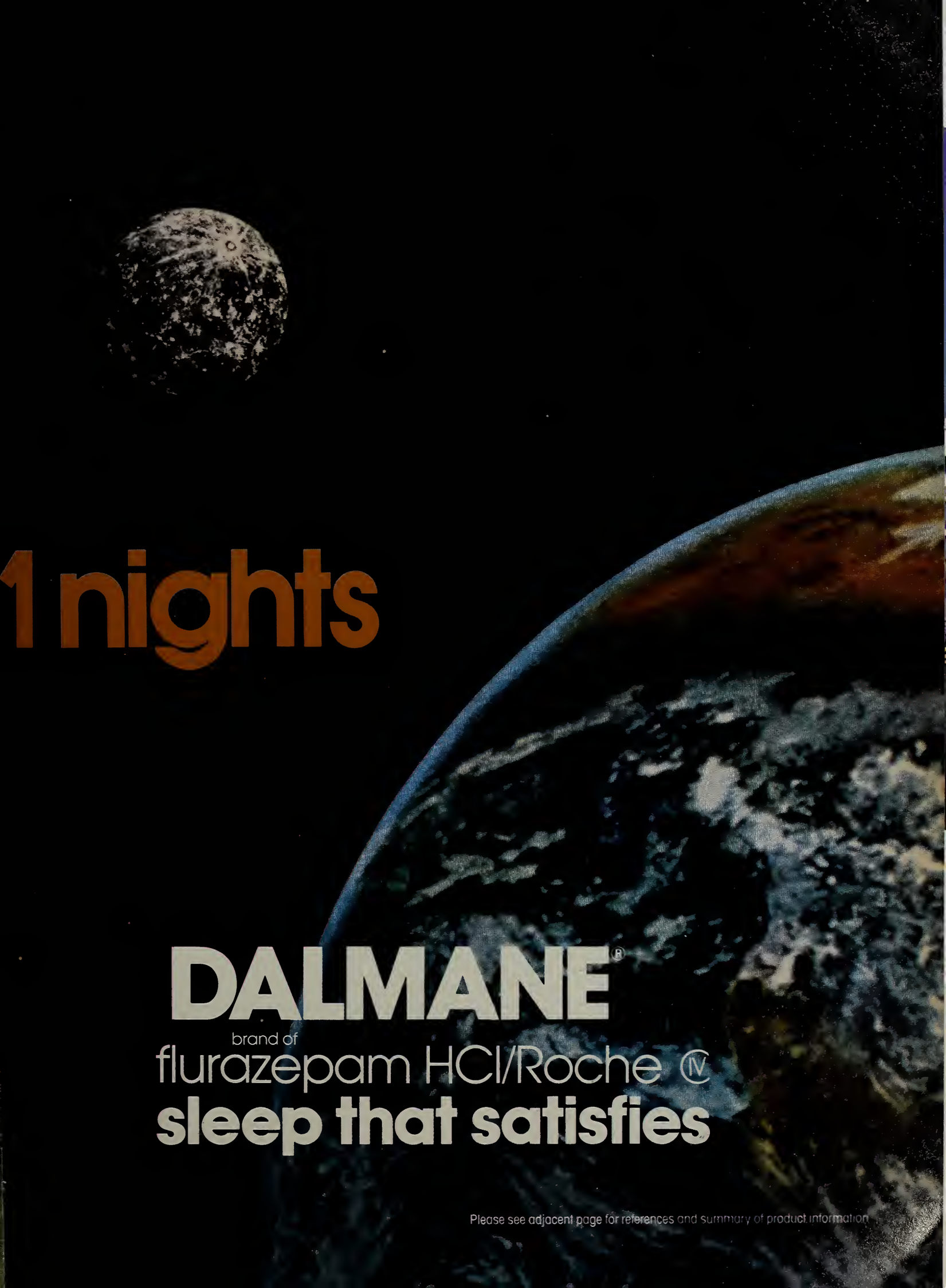
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References: 1. Kales J, *et al: Clin Pharmacol Ther 12:*691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Pharmacol Ther 18:*356-363, Sep 1975. **3.** Kales A, *et al: Clin Pharmacol Ther 19:*576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32:*781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27:*541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med,* pp. 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3:*140-150, Apr 1983. **8.** Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21:*355-361, Mar 1977.

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FROM THE EDITOR

American Health Care — the Best in the World

America has a reputation for having one of the best health care delivery systems in the world — but, sometimes, we have a tendency to forget that. With the bigger and better machines medical technology is turning out each year, it's easy to get blasé about equipment and techniques that other countries can only dream about.

To bring things back into perspective for you, Cleveland neurosurgeon (and frequent *Journal* contributor) Robert White, MD, provides us with a look at three faces of medicine — as it is practiced in China, the Soviet Union and our own technologically sophisticated country. Drawing from his own experiences in each of these nations, he contrasts and compares systems that will, ultimately, make you grateful for our own manner of delivering care — no matter how flawed (or wrapped up in red tape) you may think it to be.

In other stories this month, we bring you an informative look at the changes going on at the State Medical Board. Ever since a series of articles appeared in the *Cleveland Plain Dealer,* the Board has been the subject of some intense public and legislative investigation. Ray Bumgarner, the new Director of the State Medical Board, tells about the effect these investigations have had on the Board's structure, policy and charges. If you haven't kept yourself abreast of these changes, you'll want to read the article by Associate Editor Susan Porter. It not only details these changes for you, but provides you with a list of Board members and investigators for each area of the state. Separate sidebars on the two newest physician-members on the Board are also included.

Because October is the month before elections, we have also included an article on the OMPAC Board. These are the physicians who see to it that medicine's interests are well-represented — both at the Statehouse and at the Capitol Building in Washington. If you are not now a member of OMPAC, you should find out why you should be . . .

Deborah Athy, the *Journal's* Assistant Editor, has written a timely article on "Are You Practicing Preventive Medicine?" In today's climate, where clamors are constantly being heard to lower health care costs, preventive medicine is becoming health care's hottest topic. Find out if you're practicing preventive medicine, and, if not, how you can incorporate it into your practice.

Ohio Medi-scene, this month, takes a look at the woman physician's role in health care (as viewed by woman physicians), a free health care clinic for athletes, administered by OSMA Councilor John F. Kroner, Jr., MD, and a look at the free eye-care Ohio ophthalmologists are providing the state's elderly.

Next month, the *Journal* will take a look at the subject of hospitals and how their new competitive role is changing and shaping the health care marketplace. It's an issue you won't want to miss!

Karen S. Edwards

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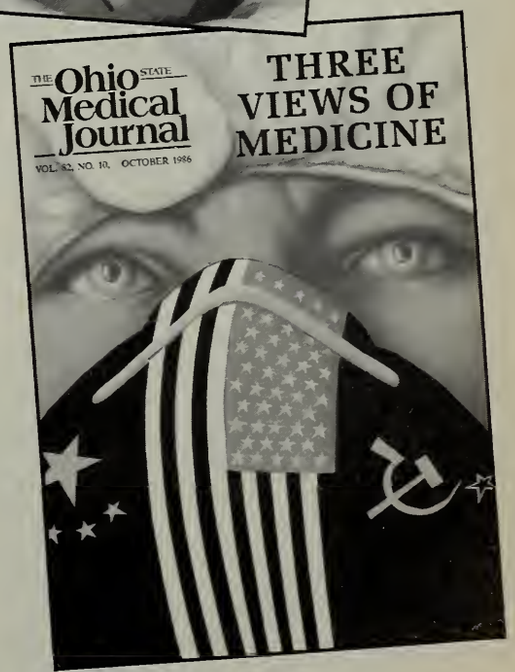
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PRESIDENTIAL PERSPECTIVES



As this time of the year approaches, the political campaigns are reaching their heights and we should become involved in this political process. As physicians, we have a responsibility to our community and to the profession, to become involved in the process of election of our future leaders in government. This responsibility should extend to understanding of the issues and campaigning for those individuals and issues that we believe are important.

Often-times, it is said by many: Why should I get involved? There is very little that I can do. The politicians are going to do it whatever way they wish anyway. These statements reflect a very naive attitude and a false conception. It is certainly embarrassing to read figures on the habits of voters and to find that an extraordinarily low number of physicians in the United States exercised their privilege of casting a ballot in the last presidential election. There is even more prevalent absenteeism on many local and state issues.

At the present time, there are over 100 bills within our state legislature affecting health care in one way or another. We at the Ohio State Medical Association have a strong lobbying force protecting as much of the physicians' rights as possible in the political climate in which we exist. Two previous pieces of legislation in which we had a tremendous impact were the recently passed Nurse Practice Act and the new bill of the Ohio State Medical Board. In September of this year, we introduced our tort reform bill on professional liability. Our lobbyists can only do so much. They need our grass-root support which comes by contacting your legislators, your representatives, and making your position known to them. Help that representative to understand what our problems are and then show him how serious you are, and how involved you want to be, by giving him support in his campaigns, including financial support. There are many of us, I know, who do not like to become involved in the political aspects of life and will let the other person do it. This attitude may be the reason that we have so many difficulties existing.

The Ohio Medical Political Action Committee (OMPAC), which is bipartisan support to candidates, has only 10-15% membership out of a possible 15,000 membership of the medical association. By becoming an OMPAC member, you can exert an influence! It is amazing what we have been able to accomplish through the support of individuals who are favorable to medicine. This is accomplished by supporting them in their campaigns and by helping them in their understanding of health issues.

At the state level, we as physicians are constantly fighting the battles of the chiropractors, podiatrists, chiropodists and many other allied health professionals who want to be considered "physicians." We need your help to carry on these battles. The other associations of allied health professionals plus unions and other interested groups contribute a far larger amount through their PAC systems or by individual contributions than we. Our members constantly complain about more and more intrusion into the practice of medicine by these groups yet are apparently unwilling to support us in our battles.

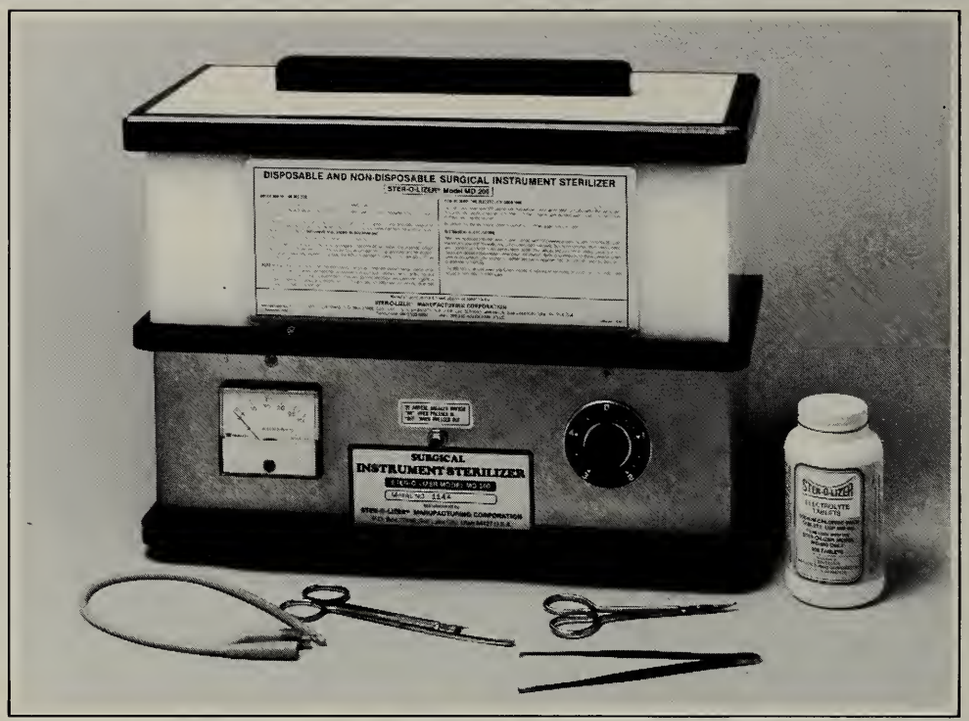
WE NEED YOUR HELP. WE CANNOT DO IT ALONE. I am asking you to consider joining OMPAC or, if you are not inclined to be a member of OMPAC, to find out who your candidates are, contact them, talk to them about the medical issues and support them.

I cannot emphasize enough to you the importance of the Supreme Court race between Justice Celebreeze and Tom Moyer. Study these candidates, their qualifications and the recommendations of the Ohio Bar Association. Make an intelligent decision and support your choice — verbally and financially.

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LETTERS TO THE EDITOR

Hospital advertising

To the Editor:

I am writing in response to the letter by Donald C. Martin, MD, regarding hospital advertising and appearing in the June issue of the *Journal.* Dr. Martin's criticisms of hospital advertising are predicated on a number of assumptions with which I disagree.

First, the cost of advertising is anything but large or incalculable. The American Hospital Association estimates the cost of hospital advertising nationwide at one-half of one percent, compared to 5 percent of total expenses for private industry. Procter and Gamble alone has a larger advertising budget than all the hospitals in this country. The minimal cost of hospital advertising may prove to be an excellent investment in the health care cost-containment effort. Specifically, most hospital advertising is educational, promotes preventive medicine, and encourages the use of outpatient services rather than the utilization of comparatively more expensive inpatient care. Advertising is a manifestation of the very competitive environment in which hospitals presently find themselves. Intense competition will only serve, as it has in the private sector, to contain or perhaps even reduce health care costs.

Second, Dr. Martin indicates that the public does not "need to know" the information disseminated through hospital advertising. To the contrary, recent survey results indicate that close to three-quarters of health care consumers respond positively to hospital advertising, finding it to be useful and informative, with an even higher positive response to those advertisements which call attention to alcohol, drug treatment, and outpatient services.

Third, the proposed solutions to this perceived problem would be counterproductive. For example, regulation by state agencies would most certainly add to the cost of health care and would in all probability constitute an illegal restraint of trade.

Physicians, such as Dr. Martin, certainly have a right and responsibility to express any objections they might have to hospital advertising. (In fact, some hospital staff physicians in northwest Ohio already have the opportunity to review advertising copy, offer suggestions, and sign off on the final version.) However, I would hope that those physicians who find hospital advertising objectionable eventually recognize it as helpful to consumers in making informed health care choices.

Sincerely,
W. Scott Fry, President
Hospital Council of Northwest Ohio
Toledo

Clearing confusion on private practice option

To the Editor:

It was with great dismay that I read Susan Porter's report of the final session of the House. On page 453 she reports that "the House . . . calls for the OSMA to work aggressively for the cancellation of the Private Practice Option portion of the NHSC Program." In fact, the House approved Amended Substitute Emergency Resolution 05-6 which was sponsored by the 10th District Delegation. This resolution did indeed ask for immediate review by the National Health Service Corp. of the situation in Sandusky County. However, rather than eliminating the Private Practice Option, this Resolution called for its proper application and "that the Ohio Delegation to the AMA submit a resolution to the House of Delegates requesting the AMA Board of Trustees and Legal

continued on page 683

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SECOND OPINION

Hospitals and County Medical Societies:

Should they be better bedfellows?

By George D.J. Griffin, MD

Most of the physicians in offices of the county medical societies and most of their respective executive secretaries make exactly the wrong assumptions in trying to plan the future of medicine. I speak in praise of their energetic efforts, but they have structured their organizations without regard to the natural impediments in dealing with the profession of entrepreneurs and their antagonistic institutional loyalties. The most recent example of this is the opinion of Dr. Juan A. Ruiz of the Mahoning County Medical Society.

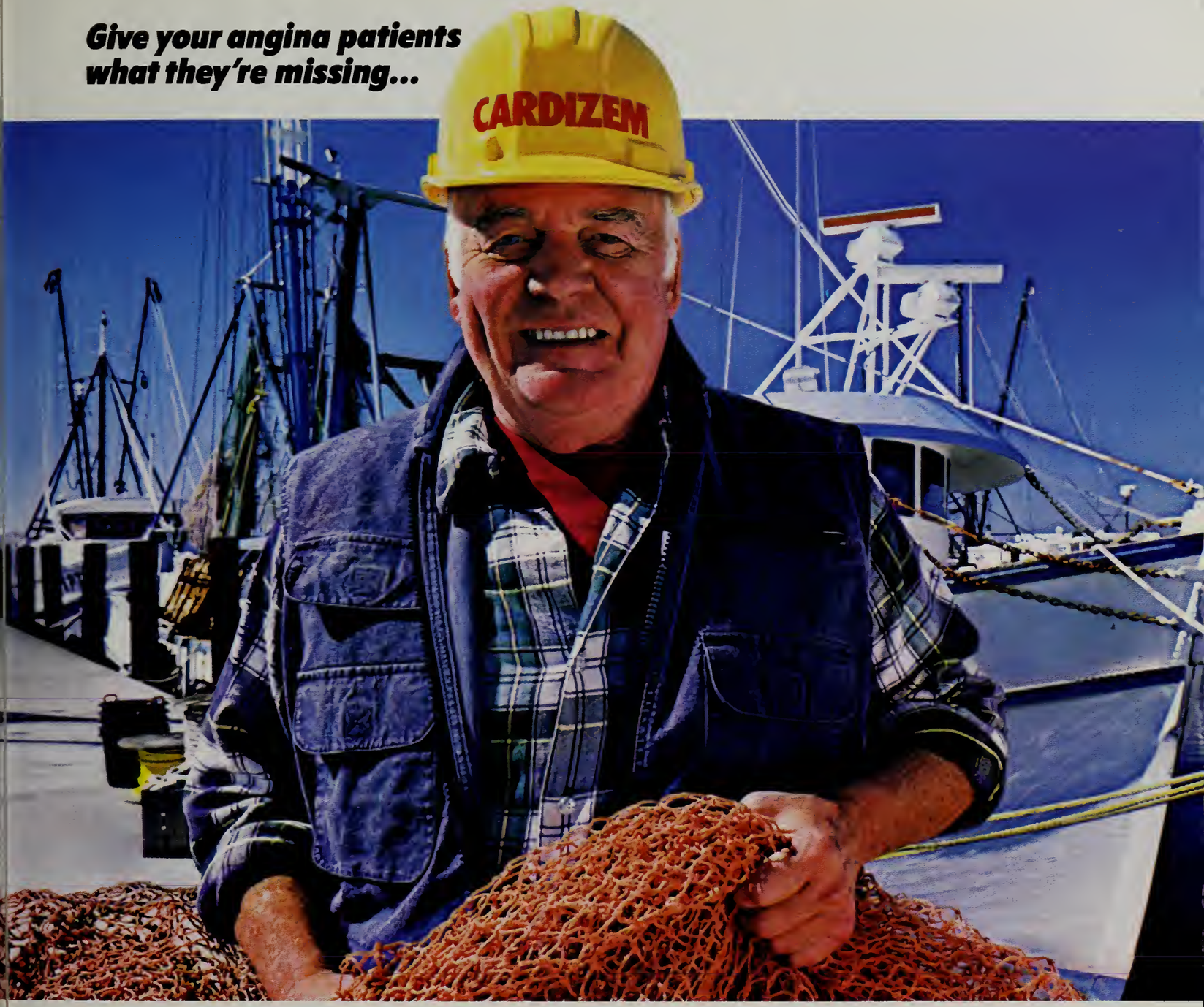
First, and foremost, I wish to call attention to the fact that the private practitioner, of whom I speak principally, is spread across the landscape in the hand-to-hand struggle of the private practice of medicine. His/her loyalty is first to his practice, his family and himself. Second in importance is his/her loyalty to the hospital(s) which is the focus of his practice. Think for a minute what this entails; for the few days in the week and many hours in the day to which the practitioner puts his energies, the only organizational structure to which he pays any attention is his hospital(s). He knows of the existence of the county medical society, the state medical society, and the American Medical Association. If he had any formal introduction into these societies as a youth, he has long since forgotten it and bears no loyalty to any one of the three. As his life progresses, he acquires and builds his professional friendships in the hospital, becomes aware of the hospital organizational structure and the levels of offices/responsibilities of the medical staff with their respective dignities. There isn't a day of his practice in which he is not reminded vigorously of his relationship to the hospital and indirectly of his dependency upon the medical staff organization. It is the only voice to which he can express his daily frustrations and suggest intelligent alterations which directly attend his future, in his opinion.

What then is the ideal structure of a county medical society? How would you attract the attention and participation of his independent, self-centered, harassed group of entrepreneurs? Would you form a separate organization, paying no attention to his established loyalties and operate from a central downtown location a closet organization vaguely related to education and/or political opportunity? Would you feel that by having five percent participation, you had therefore structured the organization properly? Would you truly think that the meetings of the medical society logically take precedence over loyalty to the medical staff of the hospital?

There is no doubt that some of the problem of county societies in attracting attention of physicians has been the "fat-cats" state of a whole generation of practitioners for whom there has been no needed expediency. But this magnifies the intellectual negligence of those in position of medical leadership at the county and higher levels who did not structure these levels better to attract attention and greater participation of the practicing physician. All the more their failure for not having done so at a time when there was more time for this to be done, when the problems were less threatening and the

There is no doubt that some of the problem of county societies in attracting attention of physicians has been the "fat-cats" state of a whole generation of practitioners . . .

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***See Warnings and Precautions.**

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CARDIZEM is controindicated in (1) patients with sick sinus syndrome except in the presence of o functioning ventriculor pacemoker, (2) patients with second- or third-degree AV block except in the presence of o functioning ventriculor pacemoker, ond (3) patients with hypotension (less thon 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refroctory periods without significontly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rorely result in obnormolly slow heart rates (particulorly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitont use of diltiozem with beta-blockers or digitolis moy result in odditive effects on cordioc conduction. A patient with Prinzmetol's ongino developed periods of osystole (2 to 5 seconds) after o single dose of 60 mg of diltiozem.*
2. ***Congestive Heart Failure.*** *Although diltiozem hos o negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humons with normal ventriculor function have not shown a reduction in cordiac index nor consistent negative effects on controctility (dp/dt).*
   Experience with the use of CARDIZEM alone or in combinotion with beta-blockers in patients with impaired ventriculor function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy moy occosionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instonces, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, ond other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most coses, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiozem hydrochloride) is extensively metobolized by the liver ond excreted by the kidneys ond in bile. As with any new drug given over prolonged periods, laboratory porometers should be monitored at regular intervals. The drug should be used with coution in patients with impaired renol or hepatic function. In subocute ond chronic dog ond rat studies designed to produce toxicity, high doses of diltiozem were ossociated with hepatic domoge. In speciol subacute hepatic studies, orol doses of 125 mg/kg ond higher in rots were ossociated with histologicol chonges in the liver which were reversible when the drug wos discontinued. In dogs, doses of 20 mg/kg were olso ossociated with hepatic chonges; however, these chonges were reversible with continued dosing.*

Drug Interaction. *Phormocologic studies indicate that there moy be odditive effects in prolonging AV conduction when using beta-blockers or digitolis concomitontly with CARDIZEM. (See WARNINGS.)*

Controlled ond uncontrolled domestic studies suggest thot concomitont use of CARDIZEM ond beto-blockers or digitolis is usuolly well tolerated. Avoilable dato ore not sufficient, however, to predict the effects of concomitont treatment, particularly in patients with lefl ventricular dysfunction or cordioc conduction obnormolities. In healthy volunteers, diltiozem hos been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats ond o 21-month sfudy in mice showed no evidence of corcinogenicity. There wos olso no mutogenic respanse in in vitro bocteriol tests. No intrinsic effect on fertility wos observed in rats.*

Pregnancy. *Category C. Reproduction studies hove been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (an a mg/kg basis) thon the daily recommended therapeutic dase has resulted in embryo and fetol lethality. These doses, in some studies, have been reparted to cause skeletol abnarmalities. In the perinotol/pastnatol studies, there was some reduction in early individual pup weights ond survival rates. There was on increased incidence of stillbirths at doses af 20 times the human dose or greater.*

There are no well-cantrolled studies in pregnant wamen; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiozem is excreted in human milk. One repart suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children hove nat been established.*

ADVERSE REACTIONS

Serious adverse reactians have been rare in sfudies carried out to date, but it should be recognized that patients with impaired ventriculor tunction ond cordioc conductian abnormalities have usuolly been excluded.

In domestic placebo-controlled triols, the incidence of odverse reactions reparted during CARDIZEM therapy was nat greater thon that reparted during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasanably assaciated with the phormocology of colcium influx inhibition. In many coses, the relationship to CARDIZEM hos not been estoblished. The most common occurrences os well os their frequency of presentation ore: edemo (2.4%), headoche (2.1%), nouseo (1.9%), dizziness (1.5%), rosh (1.3%), osthenio (1.2%). In oddition, the following events were reported infrequently (less thon 1%):

Cardiovosculor:	*Angino, orrhythmio, AV block (first degree), AV block (second or third degree — see conduction worning), brodycordio, congestive heart foilure, flushing, hypatension, palpitations, syncope.*
Nervous System:	*Amnesio, goit obnormolity, hollucinations, insomnio, nervousness, paresthesio, personolity chonge, somnolence, tinnitus, tremor.*
Gastrointestinol:	*Anorexio, constipation, diarrhea, dysgeusio, dyspepsio, mild elevations of olkoline phosphatose, SGOT, SGPT, ond LDH (see hepatic wornings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticorio.*
Other:	*Amblyopio, dyspnea, epistaxis, eye irritation, hyperglycemio, nosol congestion, nocturio, osteoarticular pain, palyurio, sexuol difficulties.*

The following pastmorketing events have been reparted infrequently in patients receiving CARDIZEM: olopecia, gingivol hyperplosia, erythema multiforme, and leukopenia. However, a definitive cause ond effect between these events ond CARDIZEM therapy is yet ta be established.

Issued 7/86

See complete Professional Use Informatian before prescribing.

References: 1. *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcame after treatment af rest angina with calcium blockers: Comparative experience during the initiol year of therapy with diltiazem, nifedipine, ond veropamil. Am Heart J 1983; 106(6):1341-1347.* ***2.*** *Shopiro W: Calcium channel blockers: Actians on the heart ond uses in ischemic heart disease. Consultant 1984;24(Dec):150-159.* ***3.*** *Johnston DL, Lesowoy R, Humen DP, et al: Clinicol ond hemodynomic evaluation af propranolol in combinatian with veropamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, rondomized, crossover study Am J Cordiol 1985;55:680-687.* ***4.*** *Cahn PF, Braunwold E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cordiovasculor Medicine, ed 2. Philodelphio, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart diseose: When to use which. Mod Med 1982;50(Sept):94-116.*

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future more promising. Fie upon the American Medical Association for failing to isolate its political responsibilities independent of its educational role!

We agree that today the physician can no longer be called complaisant. Don't we also agree that an ineffectual political organization of the physicians bespeaks poor structure of this organization? I suggest that the urban physician can only be engulfed in an effective political organization by working through his maximum loyalties to his hospital(s).

As an alternative to present organizational structures, I suggest the county medical society officers should be elected along with the medical staff officers *in the hospital,* on slates where the physician is given choices of those he knows well with those ambitions he concurs. This district-type rather than at-large representation will attract more participation and voters. Place this elected individual both on the council of the county medical society and on the medical staff executive committee representing the council and you have personal representation of the physician to whom he can speak and with whom he can identify. This representative physician can then transmit to the county society and back the questions and answers to the issues which interest the practitioner. Let the stimulus exist within the medical staff organization.

There would soon be a cadre of past, present and future politically oriented and ambitious physicians who share their interest with the hospital and the county medical society political lives. This cadre would also engender a constituency whose influence and votes it can carry with it to the county society level. Further, a path of opportunity would be presented for the young physician to participate in the county medical society. These physicians would be marked among their fellows for this interest and ability, shaped and honed by their electorate, and stimulating the mutual interest in a dual direction. If this involves five hospitals, 10 hospitals, or 15 hospitals, it is still productive and self-sustaining. A rural county medical society would by the same token better be an aggregate of counties that provide a minimum of five hospitals and/or other entities which then serve the interest and future planning of the combined county medical societies and its physicians. In addition to the hospitals, HMOs, PPOs, or IPAs could be represented. This lends itself to organization of the diversities into which medicine has proceeded and which we support, providing equal opportunities and fair representation. Major problems lie today in the political arena, and medical representation should be organized to cope with that fact.

Most of all, this plan takes the mountain to Mohammed, the county society to the practitioner, at the seat of his political loyalties, correcting what has been the fundamental failure of county medical societies during my generation.

Major problems lie today in the political arena, and medical representation should be organized to cope with that fact.

I have heard active members of the medical societies for decades bemoan the lack of participation by other physicians. I have seen in my lifetime the progression of medicine into the hands of government with little resistance by a highly skilled, educated group of professionals who one would think most capable of escaping this eventuality. We neither serve our interest nor the interest of the general public because divided we are falling. And we do so partly because of the failure of those in medical leadership to see that their method of organizing the entrepreneur is a great error.

George D.J. Griffin, MD, is a surgeon in Cincinnati, Ohio.

OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians.



Physicians and the no-smoking campaign

Surgeon General Dr. C. Everett Koop envisions a society where nobody lights up. Not in a restaurant with a cup of coffee. Not in a bar. Not even at home. And he is asking physicians to make this vision a reality by the year 2000.

"Since I left Washington yesterday about this time, 1,000 people in this country have stopped smoking. They've stopped smoking permanently, and their funerals will be within the next three days. That's a terrible way to go about stopping smoking," Dr. Koop says in a recent article in the Cincinnati *Enquirer*.

"Cigarette smoking is still the most preventable cause of premature death of citizens in this land," he continues.

For this reason, Dr. Koop has launched a major offensive against the habit — which claims about 340,000 U.S. lives annually — and is calling on physicians to take the message beyond their offices by speaking at churches, community meetings and in schools.

Dr. Koop says it's essential that physicians join in the struggle toward a smoke-free society, since survey results show that a physician's no-smoking order to his patients has proven to be the most effective way to get a smoker to quit.

Pap tests for the elderly

You're never too old for preventive health care, says a report that appeared in a recent issue of the *Journal of the American Medical Association.*

The report calls for doctors in non-gynecological primary care settings to continue screening women who are 75 years of age and older for cervical cancer through use of a pap test. The reason, the report continues, is that today's elderly women, who were just leaving their reproductive years when the pap smear was introduced for cancer detection, may not have routinely sought gynecological care after their child-bearing years ended.

Yet, 16,000 new cases of invasive cervical cancer are found annually — 4,000 in women over 65. That puts the elderly in a high-risk group for developing cervical cancer, says the report, so they are urging primary care physicians (since few women of that age see gynecologists) to remember to continue giving pap tests to women who are 65 years or older.

Health care predictions

More than 75 percent of top executives who responded to a recent survey believe the United States is heading toward a health care crisis which will have employees footing more of their medical bills by 1990.

Conducted by the national employee benefits and consulting firm Mercer-Meidinger, the survey found that about 60 percent of the executives believe we are heading in the direction of a two-tiered medical system — one for the rich, one for the poor.

Edited by Deborah Athy



Dark moments

Aristotle once said, "No excellent soul is exempt from a measure of madness."

True or not, in the following list of fabulously famous individuals is a protean measure of dark moments.

One wonders, considering history, whether their "measure of madness" was inextricably connected to a "madness" for power.

Oliver Cromwell (1599-1658)
.....manic depression
King George III (1738-1820)
.....manic depression
Napoleon Bonaparte (1769-1821)
.....dark despair
Alexander Hamilton (1755-1804)
.....extreme paranoid periods
Abraham Lincoln (1809-1865)
.....suicidal depressions
Robert E. Lee (1807-1870)
.....depressive temperament
Theodore Roosevelt (1858-1919)
.....chronic hypomanic
Winston Churchill (1874-1965)
.cyclothymic, extreme mood swings
Benito Mussolini (1883-1945)
.....chronic hypomanic

Information obtained from the UCLA Study of Manic-Depressive Illness.

New test may detect osteoporosis sooner

A new diagnostic technique for osteoporosis may become as routine as mammographies, says Gordon DePuey, MD, a nuclear medicine specialist at Atlanta's Emory University.

Dr. DePuey is the creator of the dual-photon absorptiometry machine which emits rays that penetrate the body and measure bone density, providing early glimpses of any bone degenerations.

Earlier bone-scanning techniques measured bone density only in the wrist and arm, which tend to degenerate later than other bones. Dr. DePuey's machine, however, can measure bone density in the spinal column and deep-seated areas of the body where bone degeneration usually takes place first. The image is generated by computer and projected on a video screen.

Dr. DePuey foresees using the device to screen people at age 65, and every few years thereafter.

"If we can detect osteoporosis in its very early stages, we can start treatment to prevent it, before it ever starts causing problems," Dr. DePuey says.

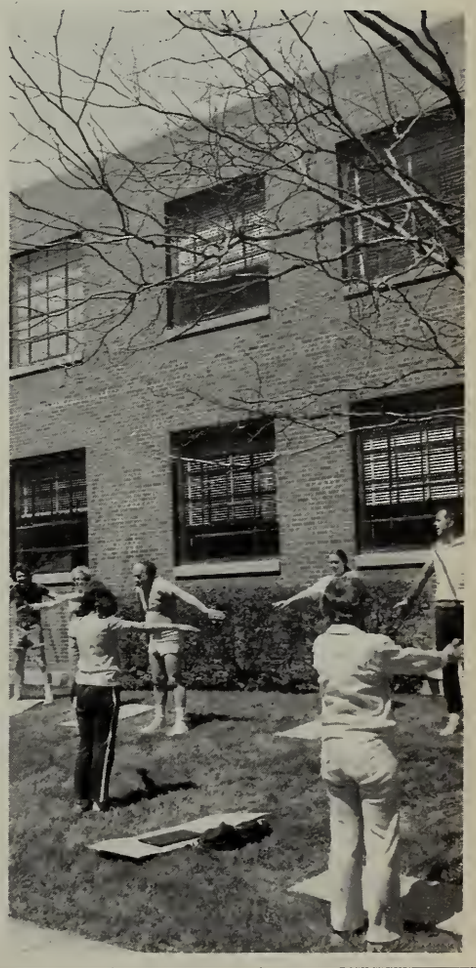
Diabetes and exercise

People with diabetes should exercise on a regular basis to maintain improved insulin sensitivity, according to a recent study reported in *Diabetes,* a publication of the American Diabetes Association.

Physicians have known for some time that exercise appears to enhance the action of insulin on peripheral tissues; consequently, diabetic people who exercise require less insulin to achieve normal blood sugar levels.

But a new study, conducted at McGill and McMaster Universities in Canada, examined just how long the beneficial effect of exercise is maintained.

The results showed that "the exercise-induced improvement in insulin sensitivity is quite rapidly reversed following cessation of regular training, in contrast to the longer term benefits of exercise on other organ systems."



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The woman physician in health care . . . medical research in Ohio . . . Ohio's team physicians . . . ophthalmologists and diabetes . . . Athens athletic clinic . . . scoliosis screening



The woman physician's role in health care

The role of women in medicine today must be the same as men — to offer good quality, compassionate health care, say 60 female graduates of the Medical College of Ohio, at Toledo, who responded recently to a survey sent them by the College's office of communications.

However, these respondents were quick to add, women physicians *do* bring to the field certain "touches" that male doctors either do not — or cannot — provide.

Four physicians, Carol Walton, MD, of Davenport, Iowa, a 1978 graduate; Mary Ruff, MD, of Newport News, Virginia, a 1979 graduate; Victoria DeVito, MD, of Lacey, Washington, another 1979 graduate; and Mary Ellen Warner, MD, of Rochester, Minnesota, also a 1979 graduate, referred in their survey to the sensitivity and compassion brought to the field of medicine by women.

The woman doctor's role is to bring a "genuine concern and the ability to counsel with an understanding that our male counterparts do not have," Dr. Walton says. "Many times in my pediatrics practice I will discuss with mothers their own medical

The woman physician's role in health care

continued

problem or questions they feel too trivial or too embarrassed to discuss with their own male physician. I believe women can show emotion more so than can a man . . . "

Dr. Ruff says women doctors approach and deal with their patients in a different way than men. "Many patients come to me because I am a woman. They feel that I will understand their problems better and be more sympathetic because I am a mother myself."

And Dr. DeVito says the woman's role is "to be available to all patients, but especially women and children who need the extra sensitivity women physicians provide."

However, Mary M. Sanders, MD, a 1979 graduate who is director of surgical pathology at the University of Arkansas for Medical Sciences, says that while the role of women is the same as that of men in medicine, "I still believe that women physicians must serve as role models for women entering the field.

Peggy Ching, MD, of Cleveland, a 1980 graduate, whose specialty is plastic surgery, agrees that the woman doctor must break new ground and enter career fields that were "previously not accessible to women. We need to make ourselves visible and pave the way for a growing future of women in medicine."

But "Women are still second-class citizens, make no mistake about that," says Sonia Hulman, MD, a 1981 graduate who practiced pediatrics and neonatology in Cleveland until a recent appointment as assistant professor at Hahnemann University in Philadelphia. "Their (women's) salaries are less, they are promoted less rapidly" — and when they do achieve positions of power, she says, they are expected to be somewhat passive when dealing with men. "If they deviate from this, they are considered — as expected — 'bitchy,' not powerful. Women need to exercise power more, and get men used to that fact."

A second physician in family practice — who asked not to be identified — commented that "Women are an integral part of medical practice. Unfortunately, the male dominated hierarchies of the professional associations and academic centers have yet to recognize the power of women in the profession, but I think they will be forced to confront it in coming years with our increasing numbers."

"Many patients come to me because I am a woman. They feel that I will understand their problems better . . ."

That is, of course, if enough women *do* make it down the road to a medical degree.

Three women physicians raised the point in their surveys that, while the roles of men and women in medicine may be equal — the paths leading to the title of "doctor' are different indeed.

"We are hampered by the fact that prime career development years and childbearing years coincide," says Ellen Nemzer, MD, a 1976 MCO graduate. Dr. Nemzer, who lives in Bexley, Ohio, and is a psychiatrist, says, "The last 10 years has seen a tremendous increase in the numbers of women physicians. Hopefully, it is just a matter of time before women physicians achieve the same level of respect and political power that men now have."

Carol Egner, MD, of Cincinnati, an obstetrician/gynecologist who graduated from MCO in 1981, comments that the woman physician's role *is* more difficult "because of time commitments to family. To become involved in medical societies, hospital committees, etc., uses up already decreasing free time."

Beverly Green, MD, of Seattle, a 1976 graduate whose specialty is family practice, says both sexes *should* have equal opportunities, which may mean that half-time practices and job-sharing should be encouraged for young physicians with children, she says.

"These positions should carry the same job status as full-time positions with the same opportunities for career advancement. They should not be hampered by things that are traditionally considered to be women responsibilities."

Yet it is the traditional *qualities* of women which make respondents believe that female physicians are a

new asset to the health-care field.

Deborah Kennedy, MD, of Dublin, Ohio, a 1978 graduate whose specialty is obstetrics/gynecology, says, "As women MDs, we can influence our patients in positive ways — by being more personal, more compassionate, and trying to change the past image of the doctor . . ."

As another respondent sums up: "Women give medicine a different touch than men." — *Jack Cairns,* Office of Communications, The Medical College of Ohio.

Medical research and studies in Ohio

• Measuring stomach activity

Larry VandeCreek, an assistant professor of family medicine at Ohio State University, is using an electrogastrogram to measure stomach activity, in hopes that such data may eventually be able to answer questions about unexplained stomach pain, as well as how the stomach is affected during periods of stress.

Because the electrical signals sent by the stomach are weak and infrequent (signals are sent only once every 20 seconds), researchers in the past have always had difficulty obtaining any measurement of stomach activity.

However, a new method has been developed which amplifies the stomach's electrical signals 1000 times, and a filter is now used to screen out electrical frequencies unrelated to the stomach (i.e. those signals which are coming from the heart).

In tests conducted so far, VandeCreek has found that strong electrical activity *is* responsible for stimulating mechanical movements of the stomach.

"A certain common sense has said emotions are tied to (stomach) butterflies," said VandeCreek in the OSU alumni paper. Now, medical technology has reached a point where such common sense can be documented.



Ohio's outstanding team physicians

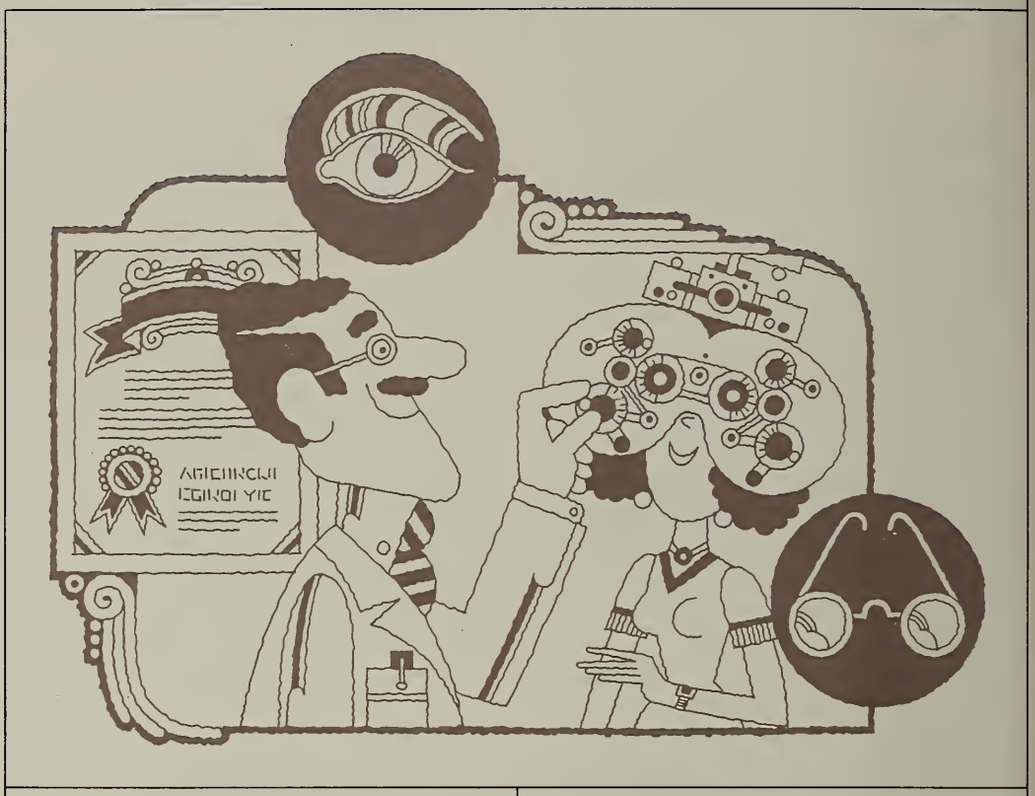
Ohio's "Outstanding Team Physicians," the title awarded to those physicians who have spent at least 25 years administering to the needs of high school athletes were recognized in ceremonies held in Canton this past July. Those honored included: (top photo) James E. Baker, MD, right, of Lima, who has served as a team physician for Lima Shawnee High School for 25 years. Michael J. Vuksta, MD, of Youngstown, chairman of the Joint Advisory Committee on Sports Medicine of OSMA and the Ohio High School Athletic Association, presented the award.

Also receiving 1986 Outstanding Team Physician Awards were (bottom photo, left to right): Ralph W. Richter, MD, Cincinnati, for more than 30 years as team physician for Elder High School in Cincinnati; Mrs. Doreen Lieber, on behalf of her late husband, Maurice E. Lieber, MD, who served for 24 years as team physician for Canton McKinley High School; and Frank W. Cianciolo, MD, team physician at Moeller High School and previously at Indian Hill High School in Cincinnati for a total of 24 years.



OHIO MEDI-SCENE

Ohio ophthalmologists work to prevent blindness



The Ohio Community Diabetes Control Program (OCDCP) of the Ohio Department of Health was awarded a one-year grant from the Centers for Disease Control (CDC), Atlanta, to develop and implement a "Prevention of Blindness Due to Diabetes" program in the 28 county Appalachian Ohio area. Endorsed by the Ohio Ophthalmological Society, the program is a cost-effective, efficient approach to the prevention of unnecessary blindness.

Because diabetic eye disease (retinopathy, glaucoma, cataracts, and maculopathy) is the leading cause of new cases of blindness among Americans between 20-74 years old, this program is being implemented to ensure that high risk patients are identified, examined by an ophthalmologist, and treated as appropriate.

Persons considered at high risk have had Type I diabetes for five duration or more years and are past puberty, or have been diagnosed with Type II diabetes and have not been under the care of an ophthalmologist during the past year.

The 11 Appalachian area program sites are located at a university outpatient medical clinic, federal clinics, hospitals, and health departments.

Designated patient education coordinators at the sites identify high risk patients and refer them through their primary care providers to the ophthalmologists of their choice for examination. If a patient is not under the care of an ophthalmologist, program personnel are encouraged to use existing referral patterns in the community. Coordinators follow up all referrals to ascertain if examination by program sites have been covered by Medicare, Medicaid or private insurance.

Because diabetic eye disease is the leading cause of new cases of blindness this program is being implemented.

The OCDCP is considering expansion of the program to 16 health care facilities throughout Ohio that are currently providing diabetes patient education services. This expansion is contingent upon receipt of operating funds from CDC for the next fiscal year.

Each new site will be encouraged to work with local physicians and ophthalmologists to develop a system of patient referral and follow-up that is mutually satisfactory to the health care system, the community and the participating site. — *Ohio Community Diabetes Control Program, Ohio Department of Health*

Athens physicians provide student-athlete physicals at no cost

Editor's note:

The **Journal** *recognizes the fact that numerous Ohio physicians donate their time at athletic clinics like the one described below.*

Although we have chosen to profile the clinic in Athens, Ohio, we by no means wish to ignore the fine work being done by physicians in other communities. The **Journal** *salutes you all!*

For the fifth straight year, Athens area allopaths and osteopaths joined forces to provide low cost physicals to students planning to participate in high school sports programs during the school year.

This year's athlete checkup marathon was held Saturday, July 26, at the offices of OSMA Councilor John F. Kroner, MR, MD. More than 150 students were tested and evaluated by the participating physicians who provided their services at no fee. The physicians were assisted by members of the Ohio University School of Medicine Sports Medicine Club. Each student is charged $12.50 for the program, with the monies used to defray laboratory costs. The bulk of the money, about 60 percent, is returned to school booster clubs for the purchase of athletic protective gear and exercise equipment.

"This program is an excellent example of how the two disciplines of medicine can work together successfully when they put their minds to it," says Dr. Kroner. "We're able to take a good look at each year's crop of athletes, review their present health problems, if they have any, and provide advice on how to take care of themselves in their chosen sport."

All student-athletes are given general physicals and screened for current and potential health problems that may be aggravated by sports participation. The doctors say it is rare that a major problem is found, but they are able to identify problems, especially with limbs, and provide advice to the students and their coaches on proper training and exercise to prevent injury.

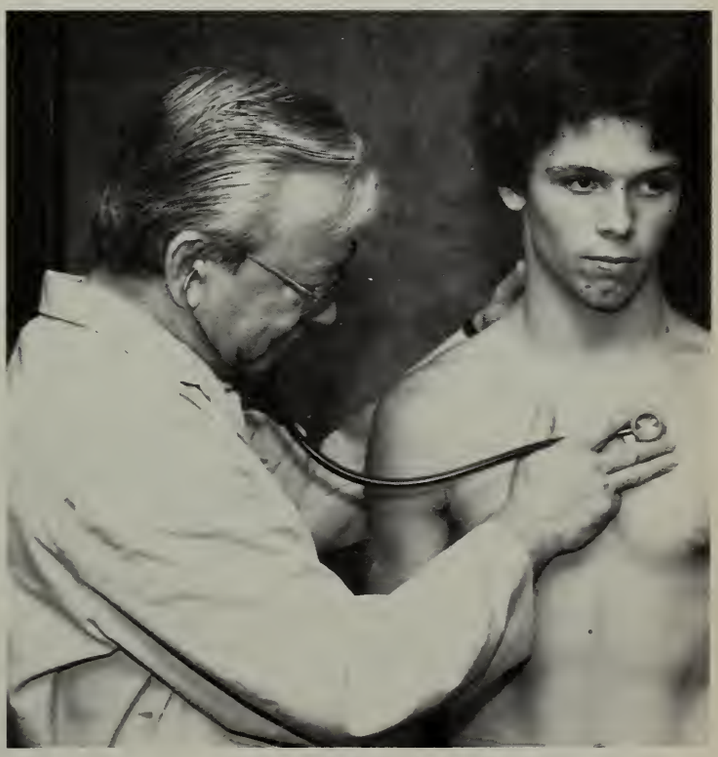
One year, Dr. Kroner said, a young flanker was having trouble catching the football. After minor eye problems were identified and glasses prescribed, the student went on to complete a successful season.

"It's good to have doctors in our community showing such attention to the students and to the community," said a coach attending the session. "These doctors are a dedicated bunch who are speaking loudly through their actions on behalf of these young people by giving freely of their time and concern."

> ***"This program is an excellent example of two disciplines working together . . ."***

Another by-product of the programs, says Dr. Kroner, is that it is an early opportunity for team members to show concern for one another. No student is denied a physical because of inability to pay, he says. In many cases, the teams organize fund-raising efforts to raise money for those students unable to cover the fee. — *Tom Cashman*





James R. Gaskell, MD (left) and Jack Knable, DO (right) donate their services each year to the athletic clinic, held in Athens, Ohio.

OHIO MEDI-SCENE

State begins training sessions for scoliosis screenings

Scoliosis screenings are nothing new. They have been conducted in Ohio's schools since 1975, but, until recently, no attempt has been made to coordinate either the training of those who conduct the screenings or the data that is gathered from them.

This November, however, Ohio's Crippled Children's Services' Postural Screening Committee will be holding six workshops throughout the state to train both new and experienced individuals on the proper method of screening for this debilitating disease.

"These workshops will be appropriate for physicians to attend," says George H. Thompson, MD, Director of Pediatric Orthopedics at Cleveland Metropolitan General Hospital and Chairman of the Postural Screening Committee.

The workshops will be three to three-and-a-half hours in length, and will consist of three sessions.

"The first session will be a general orientation defining scoliosis, discussing treatments and so on. New screening packets will be handed out which will contain a great deal of updated information," says Dr. Thompson.

The second session will break the group into new and experienced screeners, so that information can be directed toward their different levels of knowledge. Then, finally, the group will be brought back for another general session which will include, among other items, information on resources for scoliosis victims — on a community, state and national level.

According to Dr. Thompson, the reason the state has decided to finally launch a coordinated approach to the schools' screening programs is because, "in the past, we've never been sure who gets screened and who doesn't."

Since screening programs vary from school district to school district, and *some* districts (including one of Ohio's largest) make no screening programs available, it's been difficult to gather any statistical information on scoliosis in Ohio.

Despite this, however, Dr. Thompson is convinced that the school screenings *are* helping to lower the incidence of scoliosis in the state. "Seven years ago, we used to see at least one child in every school district with a case of scoliosis. Now we don't see that as much. The screenings are catching the problem earlier so that we can treat it before the curve gets worse."

The test is given to youngsters in the fifth through the eighth grade. "It is strictly a clinical examination of the back. We use the forward bend test." (The child bends forward at the waist with palms together, arms extended downward, while the examiner looks for asymmetry.)

If there is a curve of five degrees, the test will register positive, and the child will be referred to his or her family physician for follow-up tests.

That means, says Dr. Thompson, that family physicians and general practitioners may be seeing more cases of scoliosis turning up in their practices in the future — perhaps reason enough for these physicians to consider taking one of the training sessions.

"We have turned up a lot of new information about scoliosis in recent years, and doctors should be aware of this," adds Dr. Thompson.

He gives, as an example, the long-held belief that scoliosis is more prevalent in girls than in boys.

"Actually, we're finding the incidence to be about the same in both," he says. However, girls are five times as likely to have their cases progress than are boys, and that, says Dr. Thompson, is what led experts to their mistaken belief about incidence in the past.

"They were treating more girls than boys, so naturally assumed the incidence was greater in females."

The etiology of scoliosis remains unknown, however, and Dr. Thompson admits that although medicine believes inheritance factors play a role in scoliosis, "we don't understand how."

Until that crucial link of information turns up, says Dr. Thompson, early screening is still the best step in taming the problem.

If you are interested in attending one of the training workshops, they will be held at the following dates and locations:

CINCINNATI
Saturday, November 8
8:00 AM-12:30 PM
University of Cincinnati, Kresge Auditorium

COLUMBUS
Saturday, November 1
9:00 AM-12 Noon
Children's Hospital, Baxter Auditorium

DAYTON/XENIA
Wednesday, November 5
12:30-3:30 PM
Center for Health Education

Scoliosis screenings *(continued)*

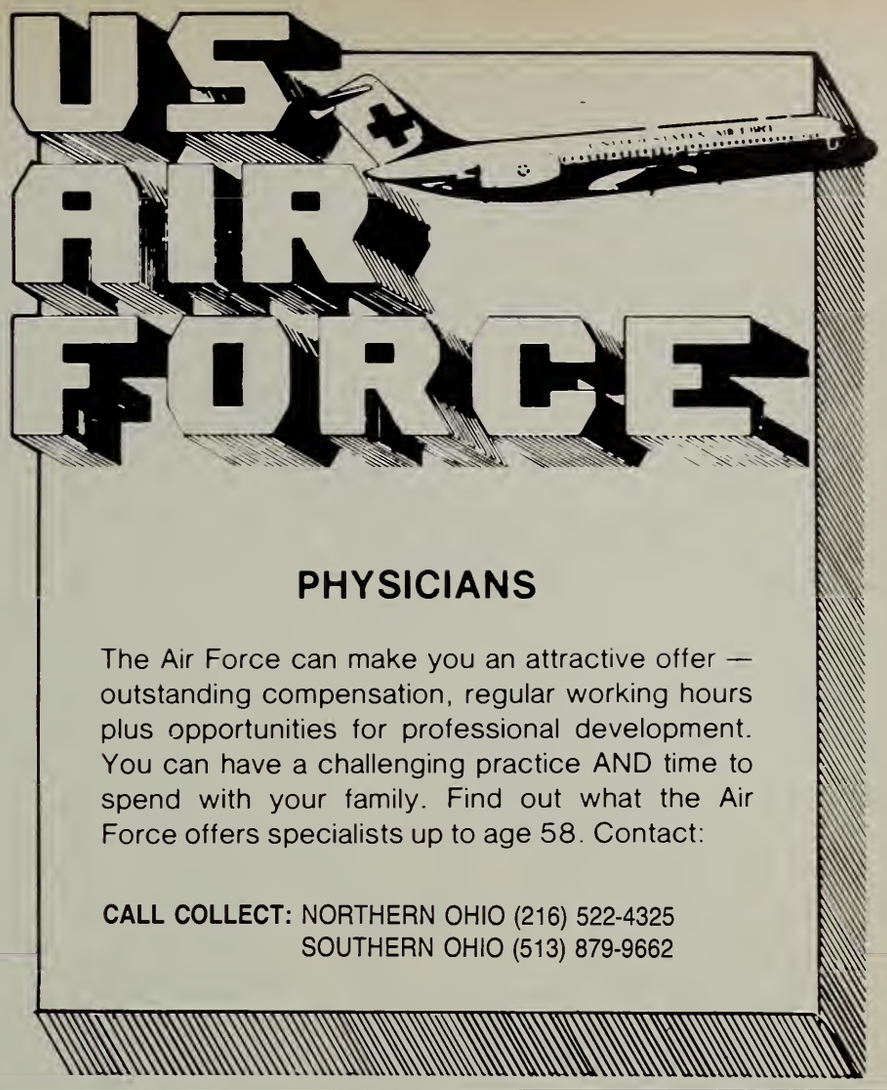
TOLEDO
Saturday, November 8
9:00 AM-12 Noon
Toledo Academy of Medicine

CLEVELAND
Thursday, November 13
1:00 PM-4:00 PM
Mayfield School Activity Center

AKRON
Wednesday, November 19
1:00 PM-4:00 PM
Children's Hospital of Akron
Auditorium

If you wish to attend one of the sessions or would like further information about the workshops, contact Susan Boelcskevy, RN, Crippled Children's Services, Ohio Department of Health, PO Box 1603, Columbus, Ohio 43266-0013. 614-461-1549.

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Three Faces of Health Care: Russian/Chinese/American

By Robert J. White, MD, PhD

Editor's note:
This article was originally presented as the Seventh Annual Dr. Harry Goldblatt Memorial Lecture at the Mt. Sinai Medical Center on March 19, 1986. Some aspects of the material dealing with Chinese medicine were presented at the Alpha Omega Alpha Lecture delivered at the Medical College of Toledo on April 9, 1985.

Medicine in the Soviet Union and the People's Republic of China has always held a certain unique fascination for the American public, in general, and for our physicians, in particular. In recent years, as our own system of health care delivery has come under serious attack from many quarters, some experts, particularly those in such disciplines as medical sociology and economics (as well as a few of our own physicians), have recommended that certain elements peculiar to the Russian and Chinese health systems be incorporated into our own medical care system. Such programs, according to these specialists, would emphasize preventive and holistic approaches to patient management, which they assume are far more "advanced" in these countries. At the same time, universal medical care would be instituted by employing large numbers of limited-trained medical personnel in a "cost-free system" by shifting the financing and control of medicine to the federal government.

While this short article will not present a major review of medical practice in these Communist countries, it will attempt to put in proper perspective those distinctive features gleaned from years of

Health care delivery in Russia is rigidly and centrally controlled in Moscow by the Ministry of Health.

visiting and studying medical care in these two countries. Additionally, this commentary should not be looked upon as a carefully constructed critique of medicine in either Russia or China.

Russian Medicine

The unfortunate disaster at the Chernobyl nuclear facility has once again led to Soviet medicine being sharply focused into the American consciousness; for, on that occasion, serious questions arose as to the competency of their health care system in adequately diagnosing and managing the mass casualties that resulted from that radioactive catastrophe. But what are the realities of Russian medicine? To be frank, this is a very difficult question to answer, but perhaps we can gain some insight into their system by examining several of its most important elements.

Health Care Delivery

Medical care in Russia in almost all of its dimensions, including hospitalization, operations, outpatient (polyclinic) care, and drugs, is *free.* The only exceptions are occasional small charges for orthopaedic appliances and glasses.

Health care delivery is rigidly and centrally controlled. The tightly managed bureaucracy in Moscow, the Ministry of Health, controls not only physicians and medical institutes, but the entire organizational design of medical practice through centralized budgeting and directives. It is interesting to note that the Russians provide only about one-tenth of the funding for health care that is utilized in our country.

Photos by Robert White, MD



In China, neurosurgeons gather to discuss a case.

While the system is relatively inefficient and evidences duplication at all levels from rural to urban, it employs over a million physicians, providing approximately 27 doctors per 10,000 persons, as compared to 16 physicians per 10,000 in this country.

Preventive Medicine

There is great emphasis on the prevention of disease and the maintenance of health through the development of appropriate personal habits in the Soviet Union. But much of emphasis on prevention is necessary because of the primitiveness of sanitation conditions and the level of public health, which is determined to a large degree by cultural and traditional factors, principally in the vast rural areas. In spite of government and medical concern, alcoholism, smoking and obesity (poor dietary habits) are still epidemic. Of equal concern to the Soviet Ministry of Health is the increase in the infant mortality rate, which has increased from 22.9 deaths per 1,000 live births in 1971 to 31.1 in 1976. These high mortality rates are not limited to infants, for the overall death rate has risen from 6.9 per 1,000 in 1964 to 9.5 in 1979. These vital statistics would seem to indicate an ill-equipped, technologically failing system.

Hospitals and Institutes

There is a great contrast between the architectural appearance, both inside and outside, of the Soviet hospital and that of comparable United States institutions. With the exception of several recently constructed modernistic institutes devoted to cancer and heart disease, these buildings appear old and of imperial, almost

The high level of medical technology and pharmacology commonplace in America is not available to the Russian physician.

Below: Open heart surgery in China.



"brooding" construction. Long and poorly lit corridors and sparsely furnished wards characterize the interiors. One does not see the almost "hotel-like" atmosphere characteristic of American hospitals. Frequently as many as 20 patients occupy these rather dismal areas, although some rooms with two to four occupants are observed.

The high level of medical technology and pharmacology that is commonplace in American practice is not available to the Russian physician. For example, hospital laboratories are marginally equipped and, as a consequence, the Russian physician orders far fewer laboratory and X-ray studies than are standard in this country. One does not see the plethora of disposable equipment in the operating room and on the wards that is such a vital part of the American medical scene.

Interestingly, even in the vital area of blood transfusions, it is obvious that the Soviet system does not have the logistical and storage capabilities that are part and parcel of the American blood replacement network. This presented a serious problem following the Chernobyl explosion in major hospitals in Kiev.

Recently available sophisticated imaging equipment, such as CT scanner, are in limited supply and are often of foreign manufacture. Cleveland has more CT scanners in place than are operational in all of the Soviet Union! At present, there are no functioning nuclear magnetic resonance (NMR), except for a research instrument in the

continued on next page

China's health care system, developed in just three decades from an almost non-existent system, is truly a monumental achievement.

Physics Department at the Moscow University, or positron emission tomography (PET) units in the USSR.

Emergency Medicine

No aspect of Soviet health care is better publicized than their emergency system. Specifically, the system is organized around unique trauma centers; for example, the large Sklifasowski Institute in Moscow, where within minutes highly trained crews in properly equipped vehicles can be dispatched anywhere in the city.

The system is linked by a first-class communication system, so that any person, by dialing a specific number and describing the emergency, can expect to have a response in an acceptable period of time by a highly trained crew (including a physician).

The emergency system emphasized on-the-scene treatment by the ambulance crew and transport of the patient to the appropriate specialized hospital. For example, a cardiac patient would be sent to an institute of cardiology.

In the far reaches of the country, the Russians have organized an extensive air-life system to handle emergencies and provide transport for patients requiring treatment at specialized institutes.

Commentary on Russian Medicine

While the Soviet system of health care is far less expensive than our own and is virtually free for all patients, regardless of the seriousness or costliness of their illness, the reality of having to wait hours to be seen by a doctor in a polyclinic and months for a routine hospital admission speaks to broad cultural and political differences between ourselves and the Russian people. In actuality, the impersonal aspect of the Soviet medical system (no private physicians) and the mediocre level of training of the average Russian doctor are really only secondary characteristics of this imperfect health care system; for the primary factor which sets American medicine apart from Soviet medicine is the ever-widening technological gap between the two systems. In simplest terms, the Russian physician of today, regardless of his or her education and experience, does not have the range of sophisticated diagnostic and therapeutic pharmacology or instrumentation to study and manage patients that the average American physician has come to expect in almost any clinic or hospital setting.

China's Medicine

China's health care system, developed in just three decades from an almost non-existent system, is truly a monumental achievement. It was originally organized and orchestrated by Mao Tse-tung and his emerging Communist leadership after the 1949 revolution, and continues today, tightly controlled by the government bureaucracy.

Today, China is a nation of over one billion people, serviced by 516,000 physicians trained in Western medicine and 436,000 assistants who have had two years of Western medical education after graduation from high school. Additional medical care is provided by 290,000 physicians of traditional Chinese medicine and approximately 1.2 million barefoot doctors with limited health training.

Barefoot Doctors

In 1981, China had 1.2 million barefoot doctors (usually young people) chosen, I was told by a medical official in Peking, "by the people" to "serve the people."

Their formal education appears to consist of three to six months training at a provincial or commune hospital, followed by on-the-job training with a physician or experienced barefoot doctor. Their responsibilities generally include first aid, immunization, health education, sanitation, simple prenatal care, and minimal general medical treatment.

I interviewed two barefoot physicians in their simple medical station, two plain rooms with a hard dirt floor. They emphasized that their medical work was directed by the tenets of Chairman Mao, and that they were "joyful" to serve the "workers and peasants" of their commune. I was very impressed by their enthusiasm while working with such rudimentary medical resources.

Recent reports suggest that the modern day barefoot doctor is going into private practice and charging a fee for his or her services! The entire Chinese medical edifice, particularly in the rural areas, is anchored by these low-level trained medical personnel, and this single economic change could be potentially devastating to the entire system.

Implantation Surgery

The large Hua Shan Hospital in Shanghai is one of the outstanding

In China, "Western" medicine exists side by side with the more classical forms of Chinese medical care . . . needling (acupuncture) and herbal medicine.

centers for implantation surgery. An entire ward was devoted to the care of patients who had undergone reimplantation of entire limbs, severed hands and feet, as well as individual toes and fingers.

When I made rounds on this ward, I was overwhelmed to see many patients with reattached whole limbs or separated parts of hands or feet, whose surgical wounds were undergoing excellent healing and demonstrating return of function. I examined six men of various ages, whose thumbs had been destroyed in accidents. Surgeons had removed toes from their feet and implanted them onto their hands to serve as thumbs. Here were tons of patients successfully regaining function following an exacting and delicate new form of surgery. Any large medical center in the United States specializing in reimplantation surgery would rarely have more than one of these patients at a time.

It was interesting to note that the patients in the ward ascribed their successful operation as much to the tenets and philosophy of Chairman Mao as they did to the skills of their surgeons. It is a fascinating medical puzzle that the Chinese lead the world in reimplantation of limbs and, at the same time, their surgical technology is so unsophisticated.

Chinese hospitals lack complex medical and surgical equipment in the operating rooms, labs and wards. Occasionally, one will see a rare piece of high technology, such as an advanced respirator or monitoring module, which, invariably, is of Chinese design and construction, but bears a remarkable resemblance to Western equipment.

Acupuncture and Herbal Medicine

Today, "Western" medicine exists side by side with the more classical forms of Chinese medical care. Needling (acupuncture) and herbal medicine are an inevitable part of the Chinese medical treatment for all diseases.

It is traditionally taught that, by expert insertion, the needles of acupuncture can equalize opposing force (the "Yin and Yang") and effect an improvement in an organ's functioning. Thus such medical disorders as heart disease, headaches, paralysis, stroke, and intestinal obstructions are treated by these methods.

Literally thousands of herb preparations are used. Some have found their way into Western medicine; for example, such alkaloid derivatives as ephedrine and reserpine. Even in the most advanced hospitals, one sees herbs unknown to Western physicians given orally or applied in the form of poultices.

While major operative procedures are conducted under electro-acupuncture anesthesia, many are not, including open heart surgery and the repair of cerebral aneurysms. In actuality, modern advances in both medicine and surgery are available only to a fraction of the population.

Other Interesting Notes

Medical care in China is not free. Charges vary, depending upon whether the treatment is rendered in the city or in the country. A metropolitan hospital room per day costs over $5, and a country hospital charges over $3, both excluding food. Unit charges are also made for procedures; for example, $2 for a chest X-ray. It is well to remember how low incomes are in China.

Interestingly, not only is malpractice not a factor in Chinese medical practice, but also bioethical controversies seldom arise and simply are not operant within their heath care system.

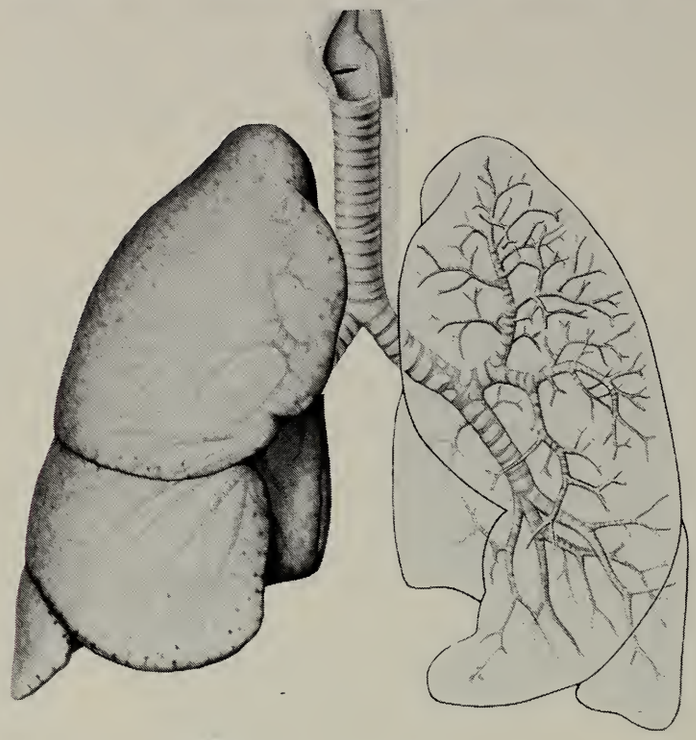
Commentary on Chinese Medicine

In many ways, the realities of Chinese medicine are wrapped in illusions. The health methodologies developed after the Revolution, dealing with monumental public health and hygiene problems, have no relative equivalence in this country. Also, the organizational strategies employed were ruthlessly imposed by a totalitarian government reaching even into the family unit.

Even acknowledging the apparent success of the program, at least in those areas examined by foreign observers, there is mounting evidence of growing popular dissatisfaction with standard health care delivery within the present system. With time, it is highly probable that as China alters its economic and political orientation (and moves toward a more individualistic "labor-intensive self-rewarding" system), this tightly controlled, non-competitive system of medical care will fail. The realities of Chinese medicine are there; the illusions are simply our attempts to interpret these realities in the framework of Western medical practice and design.

continued on page 675

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- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
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- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
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Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
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- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

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Robert J. White, MD, PhD, is a professor of Neurosurgery, Case Western Reserve University, Director of Neurosurgery, Cleveland Metropolitan General Hospital, and a frequent contributor to the Ohio State Medical Journal.

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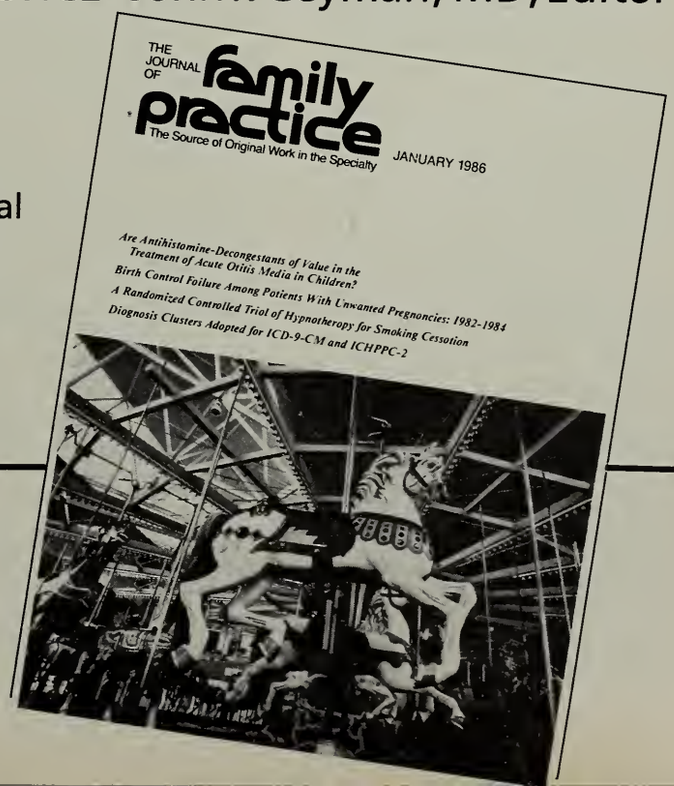
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The Ohio State Medical Board

An Interim Report

By Susan Porter

It's been a year and a half since "Doctoring the Truth," a series of articles published in Cleveland's *The Plain Dealer,* took a critical look at the makeup, actions and activities of the 11-member Ohio State Medical Board. The articles, which appeared throughout the month of April 1985, accused the board of being secretive, inconsistent and much too lenient in dealing with those physicians found in violation of the Medical Practice Act.

"The medical board has compiled an appalling record of protecting the reputations and livelihoods of the state's medical outlaws," said an article which appeared in a front-page story on April 7, 1985. Another stated: "Many cases of improper or illegal prescribing of controlled substances are disposed of by the medical board in secret hearings, which end with the physician surrendering his federal license to prescribe controlled drugs. The medical board has refused to release any information about those hearings or the license surrenders. The board has also refused to release any information concerning the possible reinstatement of those licenses," it continued, listing the names of some 51 Ohio physicians who, since 1980, had voluntarily turned in their licenses to the board.

Through sensationalized headlines including "Dangerous doctors free to prey on you," and "Board makes sure ex-con addict keeps his license," Cleveland's daily newspaper caught the attention not only of the public, but also of state legislators who called for immediate action to remedy the situation. What resulted was a seven-month investigation of the medical board by a special subcommittee of the Ohio House's Health and Retirement Committee, headed by State Representative John D. Thompson, Jr. of Cleveland.

The subcommittee's investigation, like the newspaper articles, pointed to a variety of weaknesses in the way the medical board dealt with its responsibilities. It listed a poor administrative structure, poor administrative procedures and inadequate legal tools among the inherent problems the medical board faced in its efforts to do its duties. It also criticized the board for a lack of clear disciplinary standards and inconsistencies in the way cases were treated.

"The Ohio State Medical Board has not succeeded in establishing and implementing in a systematic manner salaries, procedures and practices which fully protect the public from dangerous medical practice," concluded the 47-page report issued last November by the Legislative Service Commission.

The report also called for new legislation which would, on one hand, give the medical board more power to deal with the physicians who appear before it, yet, at the same time, would force it to be more consistent in its activities and rulings. House Bill 769 was introduced in the Ohio Legislature and was a topic of heated discussion earlier this year. After numerous revisions, the bill passed the House of Representatives and the Senate Health, Human Services and Aging Committee and it now awaits further action in the Senate.

In its current revised form, Substitute House Bill 769 expands the grounds upon which the medical board may take disciplinary action against a physician and a physician's assistant, and it permits the board to issue subpoenas in investigating any alleged violation for which the board may take disciplinary action. However, prior to issuing a subpoena, the request must be reviewed by at least two of the board's eight physician members for relevancy, materiality and timeliness.

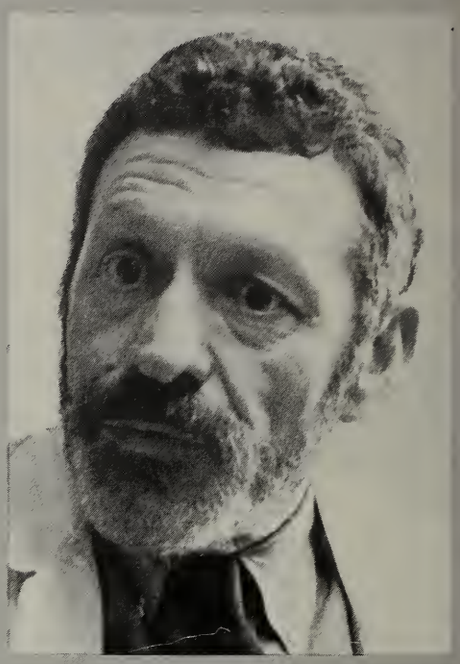
The bill also would require hospitals, prosecutors and professional associations to report to the medical board physician misconduct and any action taken against physicians, and it would require medical malpractice insurance companies to report settlements and judgements in excess of $25,000.

In addition, Sub. H.B. 769 would permit the board to suspend a physician's license without a hearing if it can be shown that an immediate and serious danger to the public exists if the physician continues to practice. Finally, it provides that any physician convicted of a felony involving injury to the person (murder, rape, sexual abuse, etc.) will have his/her license automatically suspended at

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New Board Member

Fredric B. Rothman, MD



When Fredric B. Rothman, MD, was asked to serve on the Ohio State Medical Board, he admits that he was "flattered to be asked."

"I saw it as an opportunity to be of service to the profession," he says.

In fact, however, Dr. Rothman has been "of service to the profession" ever since 1955 when he graduated from the Ohio State University College of Medicine. A Toledo pediatrician, whose practice falls primarily in the area of adolescent medicine, Dr. Rothman has been active in both numerous professional organizations, including the American Academy of Pediatrics, the Northwest Ohio Pediatric Society (over which he presided from 1982-1984), the Society for Adolescent Medicine, and the Ambulatory Pediatric Association, as well as countless community affairs. He has, for example, served as Medical Director of Project Headstart (which earned him the Community Achievement Award in 1975); on the Executive Committee of the Jail Action Improvement League; and as Chairman of the Special Project Committee of the Lucas County Mental Health Board. He is also a clinical associate professor of pediatrics at the Medical College of Ohio at Toledo.

Yet, despite his commitments, he readily accepted the position on the State Medical Board, "because I'm concerned with the quality of medical care and with the future of medicine."

He believes that this concern may have been one of the reasons OSMA councilor John Devany, MD, placed his name in nomination for the Board appointment this past spring. But Dr. Rothman confesses that it's his liberal attitude that may make him the best man for the job.

"I think my liberal point of view balances the public's perceived perception of the Board as a group of grizzled old fogies," he says with a laugh.

He is serious, however, about the job and the Board's responsibility to the public.

It's the Board's job to protect the public and implicit in this charge is improving medical care," he says.

Dr. Rothman believes that one of the ways the Board can best fulfill this function is to review the Board's supervision policies regarding medicine's ancillary personnel.

"Physician extenders have become a significant issue lately with the growth of the movement in this area," he says; and while Dr. Rothman will quickly attest to the fact that physician assistants and others who work on medicine's parameters can assume many of the functions of the physician, he is equally concerned with what effect these paraprofessionals may have on the quality of care — especially when the supervision of these groups is left unstructured.

"The Board has recently organized a committee to address this issue of supervising physician extenders," he says; and although he is not personally on the committee, he says that he intends to follow the work of this group closely.

He has little doubt, however, that they will do a responsible job.

"We have a very good Board right now and an excellent staff. There are so many people who seem to care," he says. He adds that he has been "most impressed with the youthful vigor of our legal counsel. They epitomize the best there is about the law" — which, most will agree, is high praise, indeed, coming from a doctor in these litigious times.

The fact that the Board and its personnel came under some criticism last year doesn't phase Dr. Rothman.

"I may be considered naive, but things like that don't bother me. We can't afford to be self-righteous about ourselves or our position. Boards need a little push now and then, and, in that regard, the power of the press can be helpful. I'm a firm believer in the First Amendment," he says.

He is a little more sensitive, however, when the Board is criticized for heavy-handedness.

"It's not a lot of fun to take people's licenses away. In those cases where we may have seemed heavy-handed, it is only because the situation warranted it. In many cases, we bend over backwards, interpreting the statutes as broadly as possible," he comments.

Ultimately, Dr. Rothman believes that the Board will, in some way, become the voice of progressive medicine in the future.

"I'm just glad I have been given the opportunity to participate in building that voice now," he says.

— Karen S. Edwards

By stepping up its efforts over the past year, the board has managed to whittle down the backlog — from 90 outstanding cases to 30.

the time of conviction.

In short, the legislation, if passed, would not only give the board more power in its role as overseer of the state's 27,500 physicians, osteopaths and podiatrists, but would also force it to take a tougher stance against those who come before it. "The legislative changes will guide much of the future course the board takes regarding disciplinary measures, according to Ray Q. Bumgarner, executive director of the Ohio State Medical Board since last November.

However, according to Bumgarner, who addressed those attending the Ohio Medical Society Executives' Meeting on July 30, the medical board has not been sitting idly by waiting for the pending legislation to take its effect. Rather, the board has implemented a number of changes over the past year which he feels will make it more effective in dealing with those physicians found in violation of the Medical Practice Act.

Shortly after the *Plain Dealer* exposé, board administrator William J. Lee resigned his position and Bumgarner was named acting director. In July of 1985, the board voted to open the hearing process to the public and to summarize cases in a public record.

According to Bumgarner, the board still meets the second Wednesday of each month and the following Thursday, and these hearings remain open to the public. Thus, says Bumgarner, the board can no longer be accused of disposing of cases in secret to the benefit of those physicians brought before it.

Another major criticism and a problem facing the board when Bumgarner took leadership was the large backlog of cases — many dating back to the early 1980s — that the board had yet to settle, along with the long period of time it was taking to deal with each case. "The average length of time between a request for a hearing and the completion of that hearing record was 160 days," Bumgarner told the medical society executives.

By stepping up its efforts over the past year, the board has managed to whittle down the backlog from 90 outstanding cases to 30 — all of which were initiated within the last year — and it has reduced the average completion time from 160 days to just under 60 days, Bumgarner said. "We have made headway, but we can't complete the process until a full-time hearing staff is provided to the board in the future," he added.

Another issue the board has been trying to address is its alleged weakness and lack of uniformity in taking disciplinary action against physicians convicted of drug abuse, overprescribing, fraudulent billing, sexual abuse, etc. "The *Plain Dealer* characterized us as weak in our disciplinary actions," Bumgarner said, "and we've been criticized for a lack of uniformity as well as a lack of strength."

As to the former charge, Bumgarner responded, "If you take a cross section of opinion, one-third would say we are terribly weak, one-third would say we are horribly strict and the other third would say we're not too far off. People do differ in what they think the discipline should be whenever there's any kind of regulatory situation."

The board has taken more seriously, however, the charge that it lacks uniformity, according to Bumgarner. "Strength depends on the individual case, circumstances and setting," he said, "but we do need more uniformity."

To that end, the board has, in recent months, set up some new disciplinary guidelines which are modeled on a format developed by the Federation of State Medical Boards and are used by other state boards across the country, said Bumgarner. "These guidelines are not absolutes," he reported, "but they do set up a situation for a more uniform process or decision based on the violation. And they're very tough — probably the toughest in the country right now," he added, although they are currently undergoing a second review.

In order to add more consistency to the process, the board also set up some new administrative procedures to be followed in a hearing, Bumgarner said. In this regard, the board has drafted guidelines for administrative hearings outlining how to handle appearances, consolidations of two or more hearings, continuance of hearings, motions, filing of documents, time extensions, transcripts and subpoenas.

Also over the past few months, the board has reexamined guidelines for penalties and how they are to be carried out uniformly. In a "discussion paper" regarding the effective date of board orders, board members pointed to "the need for general public protection which necessitates the physician being removed from or limited in his practice." Yet, "on the other side is the need for individual patient

Also over the past few months, the board has re-examined guidelines for penalties, and how they are to be carried out uniformly.

care which must be turned over to other practitioners in an appropriate and orderly fashion."

Therefore, as a general standard, the board decided to provide physicians who are having their licenses taken away with 30 days to close down a practice and reassign patients to another practitioner. Even this rule, however, is not set in concrete: " . . . in establishing such a time period, it should not be overlooked that some circumstances require that a suspension order be implemented immediately to avoid public harm," the discussion paper stated. "Examples might include those involving impairment, incompetence or criminal activity."

In addition, the board may decide to make some parts of an order, such as suspension or revocation of prescribing privileges, effective immediately, if that is the source of the problem. Thus, flexibility is blended with consistency in order to bring about the greatest public good, in view of the specific circumstances.

Another area that has been addressed by the medical board in recent months is the negotiations process which sometimes follows a hearing — often referred to as "plea bargaining." The board has been criticized a great deal for so-called "plea bargaining," Bumgarner said, and even some board members felt that no negotiations process should be allowed.

However, in another discussion paper drafted by the board, it was stated that: "Settlement agreements should not be neglected as a method which can bring about appropriate public protection, shorten length of time necessary to bring about discipline and minimize the use of resources. But such agreements should never be viewed or used as a method to shortchange the public."

Another criticism frequently levied against the board, not only by newspapers and government



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New Board Member

James E. Barnes, MD

James E. Barnes, MD, believes that changes to the Ohio State Medical Board were bound to happen — "whether I was on the Board or not" — but those who know the Columbus neurosurgeon can't help but feel that the restructuring may move along a little more quickly now that he's aboard.

From the moment he graduated from Ohio State University's College of Medicine in 1955, Dr. Barnes has been what corporate executive types like to call a "doer." He is listed as a member in at least 10 professional organizations, including the American Association of Neurological Surgeons, the American College of Surgeons, as well as the AMA, OSMA and the Academy of Medicine of Columbus and Franklin County (over which he presided from 1982 to 1983). He has also served as President of the Physicians Service Corporation, President of the Ohio State Neurosurgical Society, Chairman of the Franklin County Disaster Planning Committee, and as Chairman of the Public Relations Committee of the Academy of Medicine — a position that stands him in good stead, now, as a member of the State Medical Board's newly formed education and public relations committee.

Dr. Barnes, who speaks well of the Board's present members and its director Ray Bumgarner, has high hopes — both for the new committee and for the State Board itself.

"In years past, the Board has not been aggressive enough in its stance," he says, but adds that all of that is about to change.

"The new education and public relations committee will be raising the Board's visibility in the state with a two-pronged approach — one to the consumer and the other to the physician. We have already made two television spots (directed to consumers), and we'll be making three others."

The TV spots will cover such subjects as the abuse of prescription drugs, patients' rights and patients' records.

Physicians, on the other hand, can look forward to a newsletter three times a year which will cover hypothetical cases, profiles of Board members and license renewals, among other subjects, he says.

Another action which the committee hopes to put into motion soon is alerting physicians as to what they may and may not do within the scope of their practice.

"Do you know how many physicians don't *know* that you can't legally prescribe certain drugs for your family?" asks Dr. Barnes. "It's not just a moral or ethical decision in these cases — it's actually against the law, but there are physicians out there who don't know that."

If Dr. Barnes and the committee have their way, all licensed physicians in the state will know exactly what will get them in trouble with the State Medical Board by simply reading a summary of basic principles which the Board hopes to have printed on the back of license renewal cards.

These, along with the TV spots and newsletter, will help to accomplish what Dr. Barnes believes is the purpose of the State Medical Board: "To protect the public and be fair to physicians."

"Eventually, if the Board does its job correctly, we will have more physicians who are better qualified to do their job, and more physicians who are doing a good job in their practice."

But neither does he believe that Board members should sit around with sharpened axes.

"You don't need any kind of super intelligence to be on the Board, but you *do* need to be conscientious. You need to read all the material, be willing to understand both sides, and you need to be fair," he says.

Dr. Barnes believes it was his tendency toward outspokenness, as well as his ability to see things from the patient's — as well as the physician's — side that got him appointed as one of the State Medical Board's newest members.

It wasn't a position he jumped at, he admits, "but I decided things needed to be changed, and maybe I could help change them." He did, however, make his acceptance conditional upon one thing.

"I told them I'd take the position only if there were no (political) strings attached," he says.

Did that condition matter to those who make the appointments?

"Apparently not," Dr. Barnes laughs. "I got the job." — *Karen S. Edwards*

Within the next several months, a new position will be filled to act as a liaison between those who file complaints and the board.

THE OHIO STATE MEDICAL BOARD

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Vice-President
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Henry G. Cramblett, M.D.
Secretary
2480 Sheringham Road
Columbus, Ohio 43220

James Barnes, M.D.
931 Chatham Lane
Columbus, Ohio 43221

John H. Buchan, D.P.M.
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Columbus, Ohio 43215

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3609 Belmont Street
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Aurora, Ohio 44202

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16926 East Park
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Carol Rolfes
1088 Maple Cliff Dr.
Lakewood, Ohio 44107

Fredric B. Rothman, M.D.
St. Vincent's Hospital
2213 Cherry St.
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Timothy L. Stephens, Jr., M.D.
11201 Shaker Blvd., Ste. 328
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investigations but also by physicians and physician groups who provide the board with information, is that complaints, once they are filed, sometimes appear to be ignored or forgotten. Within the next several months, a new position will be filled to act as a liaison between those who file such complaints and the board, according to Bumgarner. Titled a complaint control officer, this new staff member not only will let those who call in complaints to the medical board know the status of the particular case they are interested in, but he/she also will keep the board informed on where each case stands and when and why delays exist.

"We hope this will help us lose some of the stigma of being akin to a black hole," Bumgarner said, "where a complaint goes in and disappears and it may or may not reappear in the future."

In addition, the board now has four new investigators to help it handle its growing caseload, bringing the total number of investigators in this state to 10 (see map and listing). Money also has been allotted for training seminars so that investigators can do their jobs more efficiently and effectively.

Helping both investigators and board members to deal with the growing list of responsibilities is another discussion paper drafted by the board on "investigative priorities." According to Bumgarner, the order in which cases are pursued continues to be set by the assistant attorney general and the supervisory member of the board. However, general priorities have been drafted to be followed in the absence of specific priorities.

These are (in order): "complaints involving life-threatening situations; complaints involving a potential hazard to the public's health, welfare and safety; complaints involving circumstances which have an impact upon the quality of service provided individuals; complaints involving circumstances which bear a relation to individuals' rights, but do not affect quality of care; and complaints involving circumstances which have no direct or indirect effect on the service provided individuals, but are violations of rules and regulations."

But the medical board has gone beyond looking at present and future remedies to its complex and often controversial list of responsibilities and has even taken a backward glance. "We've begun a process whereby we're going back to old complaints and reopening cases that date back years," Bumgarner said. "We're introducing these issues to the secretary and supervisory member to determine if the case warrants further action or is no longer pursuable. In some cases, we're finding that the problem is just as prevalent now as it was when it was originally reported several years ago," he said. "It may have taken a different slant, but it's still out there."

In addition to struggling with its bad image, a major reorganization, pending legislation, and a big backlog of cases it is finally managing to settle, the medical board is facing still another problem — a substantial increase in the number of new complaints. "In 1984, less than 500 complaints were filed with the medical board," said Bumgarner, who served on the board for 10 years before becoming its acting director in April 1985. "In 1985, we had just over 600 complaints, and as of July 29, 1986, some 466

With regard to impaired physicians, the board has vowed more consistency in how these cases are dealt with.

complaints were filed — we're liable to see a significantly larger number of complaints this year."

Many of the cases, however, are out of the board's jurisdiction. "The highest percentage of complaints deal with unhappiness about fee situations," said Bumgarner. "Unless there is fraud involved, the board has no statutory authority to bring any real meat to these problems."

Other things that continue to hamper the board's progress are new controls placed on them on out-of-state travel, so that they can no longer use board money to attend national federation meetings. "On one hand, there's a hard cry to upgrade the board," Bumgarner said. But on the other hand, the monies aren't being made available for self-improvement.

Still, the board continues to tackle those issues which have brought it under criticism and to explore new ways to improve its operation. Recently, the board's president assigned members to a number of special committees to address those complex issues in need of further scrutiny. These include a physician assistant committee, an impaired physicians committee, a public relations committee, a standing committee on foreign school review, and a committee to consider revisions to the Medical Practice Act.

About the last committee, Bumgarner explained, "Current law dates back to the turn of the century. We want to modernize the (Medical Practice) Act and put it in a more readable and understandable format."

The board also hopes to establish a better rapport between itself and those members of the medical community who abide by their professional code of ethics, along with members and staff of organized medicine, Bumgarner told the group of medical society executives. He also hopes the role of these organizations with respect to complaints and investigations can be more clearly defined in the near future.

"I know some (county medical societies) prefer no involvement at all, and others want to take a more active role in relation to these investigations," Bumgarner said. "This needs to be explored more."

And finally, the board has agreed to work more closely with organized medicine to make sure those physicians addicted to drugs and/or alcohol receive the attention and treatment they need. Yet, again, it has vowed more consistency in how these cases are dealt with. In a special report to the House's Health and Retirement Committee, the board outlined three scenarios that spell out how impaired practitioners are to be treated, depending on any wrongdoings that may have resulted from their impairment.

"The voluntary effort to identify and rehabilitate the impaired physician should be encouraged," said the report, referring to programs like the Ohio State Medical Association's Physician Effectiveness Program. "But impairment, in and of itself, does not justify or provide any legal excuse for any and all violations of the Medical Practice Act, or other laws, committed while impaired." **OSMA**

Susan Porter is the Associate Editor of the **Ohio State Medical Journal.**

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continued from page 655

Department to negotiate with the National Health Service Corp. to correct the serious problems with the National Health Service Corp. Program."

In my local community, we have developed serious physician shortages, and finally the Private Practice Option allowed two physicians to begin their practice as of July 1, 1986. They have been a welcome addition to our local community and we are hopeful that this option may be applied in the future for further physicians recruitment. Nearly everyone agrees that some major problems exist within this entire program, but for some smaller communities it has been a real blessing.

Respectfully,
Brian L. Bachelder, MD
Mount Gilead

Editor's note: The Journal regrets the error.

NEW MEMBERS

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Terence Isakov, MD, Cleveland
Shelia N. Run, MD, Chardon
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Subbarao Jayanti, MD, Worthington
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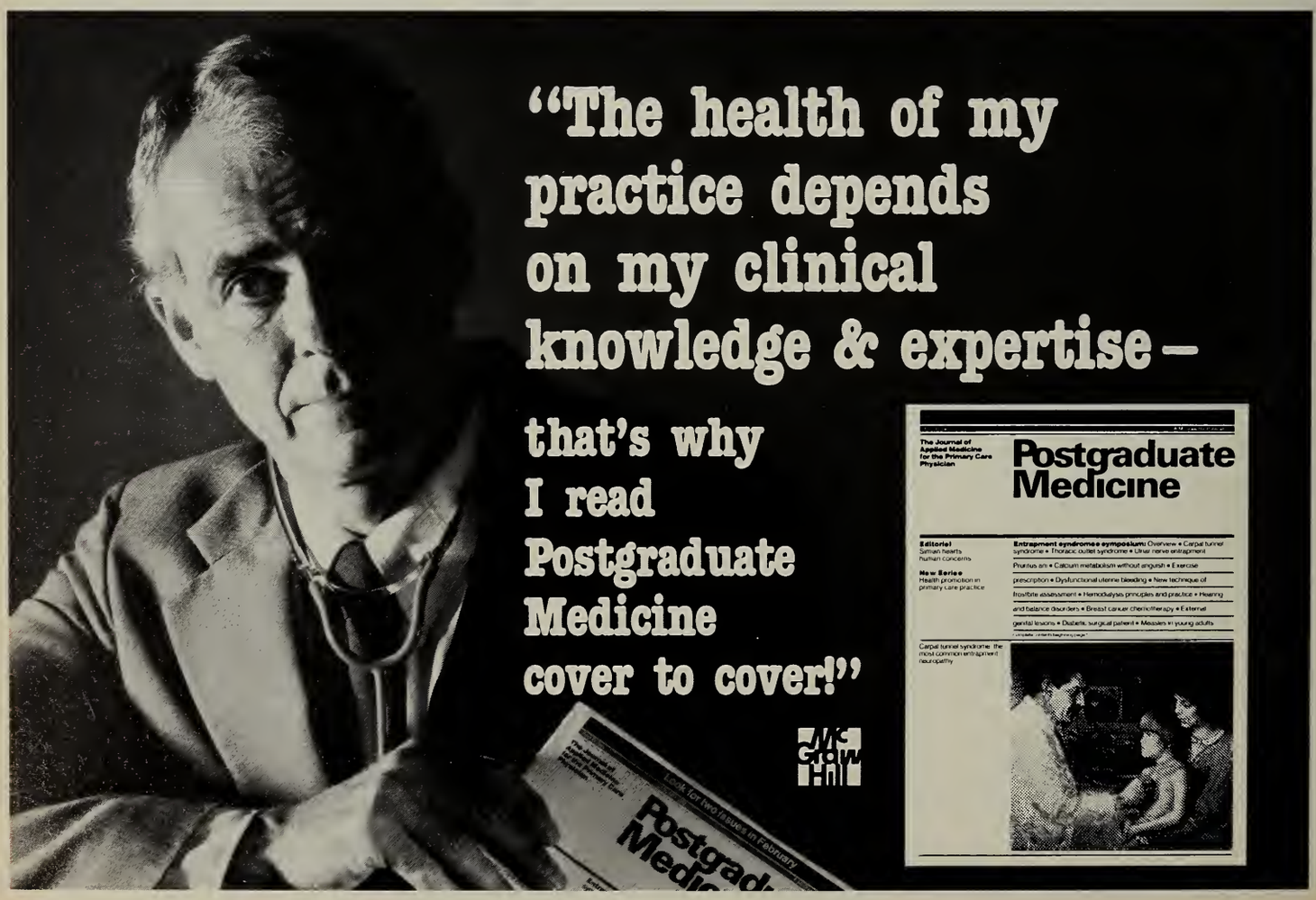
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Are You Practicing Preventive Medicine?

By Deborah Athy

When it comes to practicing preventive medicine, usually your *intentions* are good — but with a waiting room full of sick patients, it's not always easy to find the time to counsel, for example, your sunburned patients on the danger of skin cancer or your female patients on how to do a breast self-examination.

But according to Richard Lang, MD, a staff physician in the Department of Preventive Medicine at the Cleveland Clinic, it is essential that patients receive this kind of information, so that they know "what they are doing to their health and to themselves," and are aware of the various implications of their habits and lifestyles.

Dr. Lang describes preventive medicine as interventions in an individual's life which can alleviate or reduce medical problems in later years. Any preventive physician worth his or her salt will encourage patients to make these interventions in their lives, he continues.

In many cases, these interventions translate into the modification of habits, such as trimming the cholesterol from meat-and-potato dinners, cutting smoking and alcohol intake, and allocating time to exercise in a busy schedule.

Traditionally, a physician deals with medical problems as they occur. But a physician who is practicing preventively — whether that physician is a family practitioner, internist, pediatrician or obstetrician — deals not only with the immediate complaint, but looks at the patient as a whole and assesses with the patient the risks he or she may face in the future, says William Keck, MD, director of the Akron Health Department and director of Health Sciences at the Northeastern Ohio Universities College of Medicine.

"A preventive physician looks at a variety of issues not reflected in the patient's health at the moment, but which may impact the patient's health in the future," says Dr. Keck. These include the individual's current health status, his or her environment, family and personal histories, as well as lifestyle. The preventive physician will then include an assessment of these issues in his or her "standard repertoire of tactics" for treating patients, Dr. Keck says.

Drs. Keck and Lang aren't alone in their belief in the importance of preventive medicine. According to a recent government report: "Many major health problems confronting Americans today are also rooted in lifestyle or environmental factors that are, themselves, amenable to change. Health promotion and disease prevention, therefore, appear to hold the key to further improvements in the health status of the American people."

"If you look at the major health problems, you'll see that heart disease, cancer and stroke are what's killing most of us," Dr. Keck points out. Right now, Dr. Keck believes there is too much emphasis being placed on the treatment of these health problems, and not enough emphasis on prevention. "But there is a lot an individual can do to prevent these illnesses," he says.

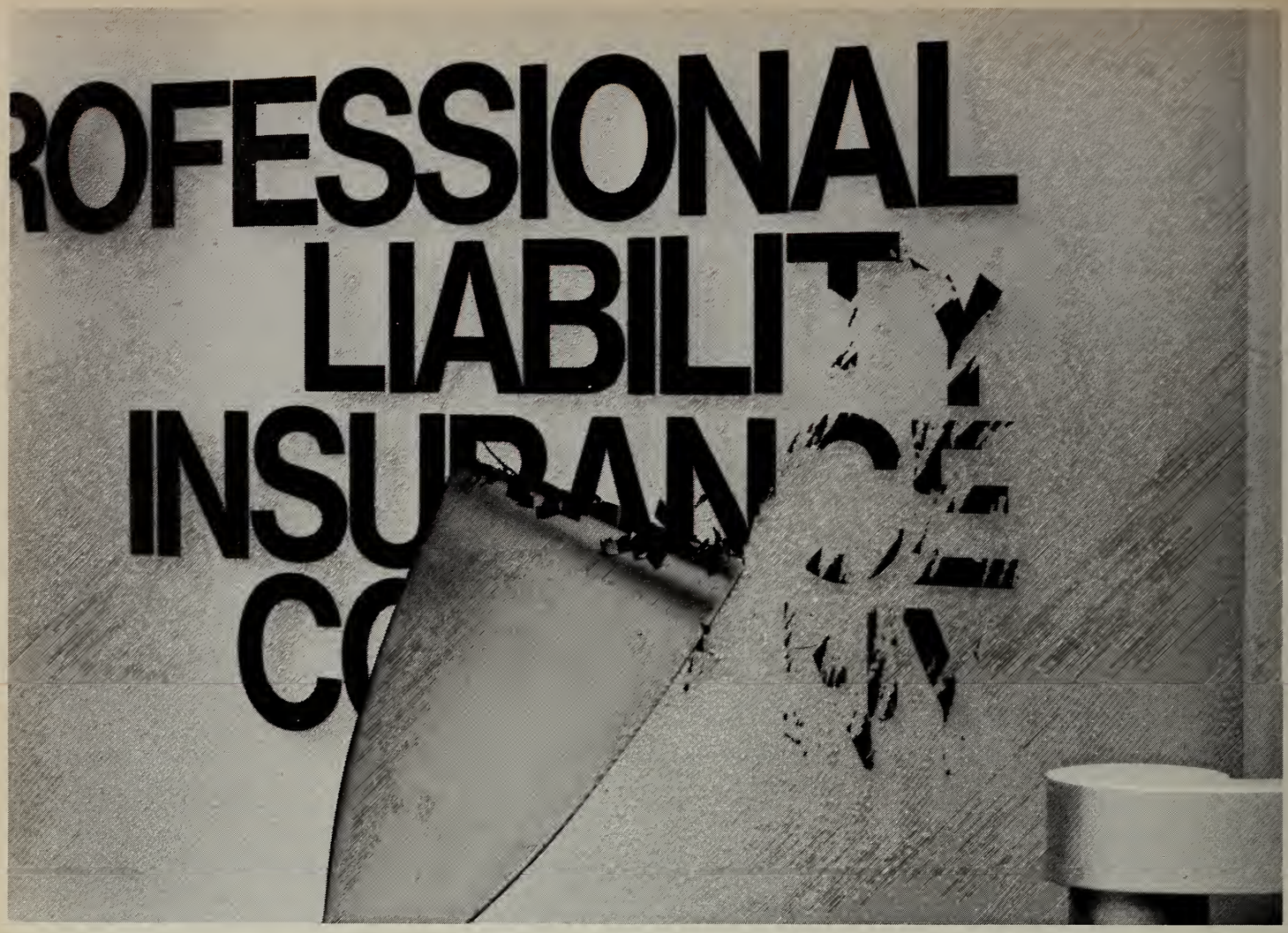
Dr. Keck cites the AMA's recent get-tough stance against smoking — which he calls "very courageous" — as evidence of a growing awareness of the importance of preventive health measures. "With their (AMA's) stand on smoking and tobacco, they are looking increasingly like a public health body."

As Dr. Lang points out, "Medicine is changing so much that they (doctors) are going to have to practice in the preventive area because of the increasing pressure to reduce health problems." There is also increasing pressure to cut down health care costs; and preventive medicine may turn out, Dr. Lang adds, to be "cheaper in the long run."

But preventive medicine is not simply limited to interventions which may improve a person's lifestyle. It also entails knowing about other community resources which are working toward that same goal, says Dr. Keck. These community resources (such as the local health department, local medical society, fire department and employment services) often offer free hypertension and HTLV-III screenings, nutrition, family and prenatal counseling, and immunization clinics.

The physicians, therefore, must initially recognize the risk factor — substance or child abuse, for example — and then refer the patient to the logical resource, Dr. Keck explains.

"There is a need (for physicians) to report communicable diseases to



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More people need to have a better idea about what their health risks are . . . a physician could help by pointing them out, then explaining what it will take to reduce those risks.

the local health department to protect the community at large," he says, adding that this networking within the community is an important aspect of preventive medicine.

The stumbling block in all of this is that preventive medicine requires what is perhaps the physician's scarcest and most valued commodity — time. It takes time to assess not only the immediate problems, but those which may surface some years down the road. And it takes extra time to handle counseling referrals, networking and additional reimbursement problems.

But there's good news in all of this too, Dr. Keck stresses. "The major issue in a lot of malpractice cases is a lack of communication." A preventive approach may enhance communication between the patient and physician, although there are no guarantees, he concedes.

Dr. Lang agrees that improved communication via a preventive approach could reduce the likelihood of a lawsuit against the physician — "the more the patient likes me, the less likely he'll be to sue" — although this remains to be seen, he says.

In any case, "I see a lot of healthy people who say 'How can I prevent something from happening in the next 20 years or so?,' " Dr. Lang says. By helping these individuals work toward this end, physicians and patients alike may find greater personal rewards.

"More people need to have a better idea about what their health risks are," he continues. "It would be helpful if a physician could help by pointing out, 'Here are your risks, here's how you can lower these risks.' "

"When it comes down to it," Dr. Keck points out, "the physician is still an authority figure. When a physician makes a suggestion about a lifestyle change, it has more impact than a radio message." This is especially true when a good physician-patient relationship exists. Likewise, if a patient heeds this advice, there is "less likelihood of illness and injury, and the patient's chances for a healthy future are improved."

"Often we request basic information from our patients for our own reference," says Dr. Lang. "But what we often have not done is analyzed the information and let the patient know what it means."

One means to this end are "health hazard appraisals," which condense an individual's personal medical history and capsulize the results in a computerized printout, says Dr. Lang.

For example, by analyzing an individual's history, you may find that a 40-year-old woman who is overweight, smokes and has high blood pressure may have a life expectancy comparable to that of a 47- or 48-year-old woman. Whereas a 40-year-old woman with good health habits may have the same risks as a 33- or 34-year-old woman. Chronologically, the woman is 40, but physiologically, she is six or seven years younger. Dr. Lang sees the worth of health hazard appraisals as somewhat limited, but says "any positive stirring up of a patient's thinking processes about their own health is worthwhile."

These health appraisals show "there's a dramatic range of life expectancies that are possible," says Dr. Keck. "If we can improve their (patients') lifestyles, we could increase their longevity and the state of life they enjoy while they're alive." OSMA

Deborah Athy is Assistant Editor of the **Ohio State Medical Journal.**

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A Profile of the OMPAC Board

By Carol Wright Mullinax and Deborah Athy

Another committee meeting. It's the last thing most physicians are interested in. Long hours and unpredictable schedules already place too many demands on the typical doctor's day.

But for the members of the Ohio Political Action Committee it is well worth the effort. They meet regularly to chart the association's political future by monitoring the political process and by determining which candidates and officeholders will receive financial support.

Contrary to popular belief, OMPAC does not lobby, nor does it take positions on legislation. That job is performed by the OSMA's Department of Legislation, headed by Richard Ayish, and directed by the OSMA's Legislative Committee, chaired by William Marshall, MD, Dayton.

OMPAC's role is to provide physicians with the opportunity to speak with a united voice in support of candidates who demonstrate a willingness to listen to the concerns of the medical profession. OMPAC is funded by the contributions of individual physicians and their spouses who once a year give $125 to become a sustaining member or $100 to become a regular member.

So what kind of physician makes time in a too busy schedule to tackle such an important and time-consuming task? The following profile of the OMPAC Board gives some interesting and enlightening looks into the hows and whys of PAC involvement.



Jerome Kimmelman, MD, Toledo

Chairman

Dr. Kimmelman, a dermatologist, has spent the past six years on the OMPAC Board, the last two as chairman. It is a time-consuming commitment, especially when he adds in his other duties, such as serving as an OSMA delegate and treasurer of the Academy of Medicine of Toledo and Lucas County. But he makes time for OMPAC because he considers it so important.

"OMPAC is the voice of Ohio physicians in the political process. Participation by doctors in governmental decision-making is essential for promoting good government as well as quality patient care," Dr. Kimmelman says.

He points out that this involvement is more important today than ever before: "Physicians are under tremendous pressure to alter the way they practice medicine. Issues facing medicine today — like scope of practice for other health care professionals, tort reform, physician fee freezes, mandatory assignment and the like — are decided in the political arena. OMPAC helps elect those persons willing to listen to medicine's point of view. That gives us an open door to having an effect on the outcome of medical care legislation."

> ***"Issues facing medicine today are decided in the political arena."***

But, Dr. Kimmelman says, as medical/legislative issues become more complex — and more common — it will become even more important for physicians to join OMPAC. "There is no physician in this state who can say his or her practice is not worth $125 a year for representation in government policy. If we don't speak for ourselves, who will speak for us?"



William H. Kose, MD, Findlay

Vice Chairman

In addition to practicing internal medicine in Findlay, Dr. Kose, vice chairman of OMPAC and Findlay County Coroner, recently received his law degree.

> ***"A candidate may not vote the way I want, but at least I know he has the facts."***

"There are probably more legal problems with the coroner's job than medical problems," he explains. In addition, he says a legal background complements his role on the OMPAC Board because it "makes it easier to logically organize an argument and direct the legislator to what the real issue is in a short period of time."

And that's the name of the game, says Dr. Kose: to communicate effectively and to make a concerted effort to get your message across. "OMPAC has a good track record" of getting medicine effectively across to legislators, he points out.

"Candidates are interested in what people think. A candidate may not vote the way I want, but at least I know he has the facts."

Joseph Sudimack, Jr., MD, Warren

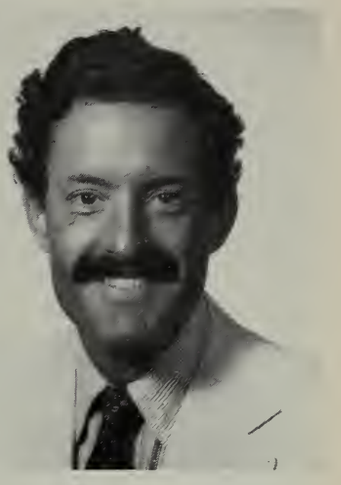
Secretary-Treasurer

As Secretary-Treasurer of both the OSMA *and* OMPAC, Dr. Sudimack *could* be perceived as someone with a banker's heart. But, in fact, he became hooked on politics after his successful bid to become Trumbull County Coroner.

Dr. Sudimack, who also has a private practice in Occupational Medicine, says his first taste of politics proved to him that physicians could have influence in the political process. "Politics influences everything we do. There was a time when MDs stayed aloof from politics and thought they were above it. But that time is gone. Physicians who truly have an interest in the needs of their patients will get involved in the legislative process."

But, as firm as this belief is, he still hasn't lost sight of how much fun politics can be: "Getting involved with PACS is like betting on a horse race. If you don't bet, you don't really have any fun. Even if it's only a $2 investment, you end up having more interest in the race and with what is going on."





William Miller, MD, Cincinnati

First District

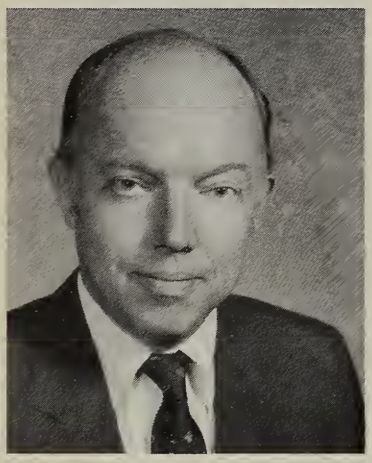
A relative newcomer to the OMPAC Board, Dr. Miller is no neophyte when it comes to politics. His interest in the legislative process has kept him involved in Cincinnati where he practices internal medicine.

This local experience has given him the opportunity to see the many concrete benefits of physicians becoming politically involved. As an example, he points to a recent meeting he and other Cincinnati physicians had with a local legislator. "We were able to supply him with the kind of technical expertise that will help him make more informed decisions in the future," Dr. Miller says.

> ***"There are always arguments. But the physicians who do get involved carry the flag for the rest of them."***

But he acknowledges that many physicians feel that politics are a lost cause, or that they don't understand the political process, or that the PAC is too much money. "There are always

arguments. But the physicians who do become involved carry the flag for the rest of them.'' He says that he doesn't mind participating for others, but he would like to see them make a donation — and to say, "Here, I'm too busy, but here's some money to carry on with the work.''



John H. Boyles, MD, Dayton

Second District

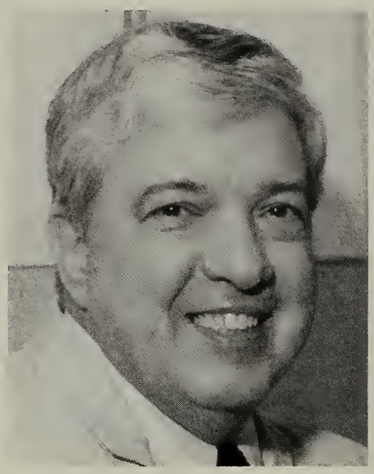
"If you haven't been involved and seen what an outstanding job OMPAC and the OSMA Legislative Staff are doing, you don't see how much they're doing to protect the medical profession,'' says Dr. Boyles, a Dayton otolaryngologist in private practice.

Currently on the board of directors of Western Ohio Health Care Plan (Dayton) and a former president of the Montgomery County Medical Society, Dr. Boyles has "been involved with political medicine for a long time.''

So what is the physician up against? According to Dr. Boyles, "The biggest threat to medicine is the question of 'who is going to do what' to whom in the practice of medicine'' — i.e., how the scopes of practice of nurses, doctors and allied practitioners intersect.

"It is vitally important for the state medical society to keep tabs on the legislative process'' — something Dr. Boyles sees OMPAC and the OSMA legislative staff working together to accomplish.

Doctors are often reluctant to get involved in the political arena, he says — a process that takes a lot of "grass roots harping and hard work'' to be successful. But Dr. Boyles looks to the day when the combined efforts of all physicians will really get things rolling.



Theodore J. Castele, MD, Cleveland

Fifth District

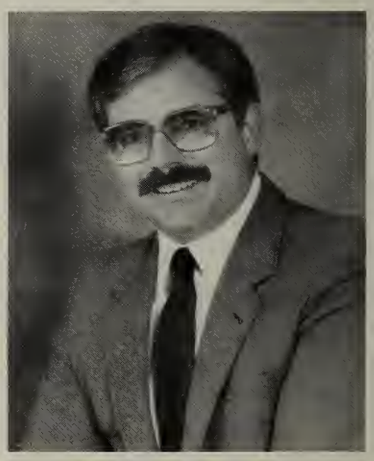
As the first television news doctor in the country, Dr. Castele has been a pioneer in presenting medicine's issues to the public. Similarly, during his four years as an OMPAC board member, he has been working to bring medicine's message "to the candidates for public office to make them aware of the concerns of physicians.''

"OMPAC raises the issues of physicians to politicians."

In addition to his duties as Cleveland's TV-5 Medical Editor, Dr. Castele, a radiologist, is past president of the Academy of Medicine of Cleveland and of the Cleveland Radiological Society, as well as a Delegate to the American Medical Association.

But "OMPAC is the only vehicle designed to support politicians who consider the physician's point of view on health care issues,'' he points out.

"The most important thing is to provide support to those candidates who are willing to be objective and are concerned with our point of view regarding health care,'' Dr. Castele continues. "Bringing medicine's issues to these candidates' attention, and keeping communication channels open, will not only safeguard the quality of medicine, but should also improve the quality of candidates,'' he adds.



James Cottrell, MD, Steubenville

Seventh District

For Dr. Cottrell, a Steubenville anesthesiologist, the lesson he has learned from OMPAC involvement has been a matter of good news/bad news. The good news has been the realization of "how a proactive group of people can influence the body politic by their actions.'' The bad news has been witnessing how "apathetic the majority of physicians are, even when they see how they are being adversely affected.''

Dr. Cottrell says he first became interested in political involvement when he realized how much influence poli-

tics had on his practice. He would like to see his colleagues come to the same realization. "If physicians become involved, that effort will be rewarded," Dr. Cottrell says, but acknowledges that for many physicians, even the effort to vote is too much. "They complain, but they don't do anything."

Dr. Cottrell points out that political involvement doesn't really have anything to do with party affiliation. "To be effective you don't have to be a Democrat to talk to a Democrat or a Republican to talk to a Republican. The legislators listen to valid arguments with anyone." That's why, he says, "Physicians must be there to supply those arguments."



John W. Ray, MD, Zanesville

Eighth District

"I grew up with politics," says Dr. Ray, a Zanesville otolaryngologist, explaining that he received his first taste of politics when his father served in the Ohio State Legislature years ago. He also "grew up" with organized medicine, attending his first OSMA Annual Meeting nearly 30 years ago as a student AMA officer from OSU and guest of the Franklin County Delegation.

Today he has combined his two interests with a continuing involvement in medical politics, serving six years as an OMPAC board member.

Because politics continues to have a greater and greater impact on the physician's practice, physicians must be more informed about the issues and should have more input into the political process, he says. That's why contributions to OMPAC are so important: because they enable medicine's programs to evolve.

"There used to be a feeling among doctors that if they didn't think about politics or if they looked the other way, politics would go away. Some doctors had an attitude that they were 'above' politics. But I think that feeling is becoming less and less prevalent," he continues. "More and more doctors are beginning to realize how important the political process has become in their day-to-day lives."



Thomas P. Price, Jr., MD, Gallipolis

Ninth District

"The reason I got involved in OMPAC is the same reason I got involved in the OSMA," says Dr. Price, an obstetrician/gynecologist at Holzer Medical Center Clinic and Hospital in Gallipolis. "Because I think the legislative process — particularly the federal — is whittling away at physicians, looking at them with a jaundiced eye."

Dr. Price, ninth district councilor of the OSMA, has been an OMPAC board member for approximately two years. OMPAC is "the only avenue physicians have to influence the legislative process. I can't think of anything that's more important."

But it's easier said than done to get physicians involved in politics, he says. "Doctors are primarily interested in helping their patients and are not interested in politics." But, he cautions, if doctors don't start getting involved, "they're going to be left at the gate."



William T. Paul, MD, Columbus

Tenth District

If Dr. Paul had his choice, he'd rather hang a "Gone Fishin" sign on his office door, and spend his free time on the bank of some river or lake. But he made the decision to participate in OMPAC because he feels he has a responsibility to become involved. "Most physicians who don't participate in politics or OMPAC feel that those of us who do must be political zealots. That's not necessarily so. We do it because we feel that is our duty."

Dr. Paul takes this responsibility so seriously that he makes it a point, as part of his duties as Director of Family Practice Training at Mt. Carmel Hospital in Columbus, to teach residents about the impact politics has on medicine. "The nature of medical practice is a function of demands set by legislative action. If you don't know the medical/legislative function, then you don't know medicine."

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Steven K. Swedlund, MD, Bellevue

Eleventh District

In his senior year at medical school, Dr. Swedlund worked for 10 weeks in Washington, D.C., as an intern for Congressman Philip M. Crane (R-Il).

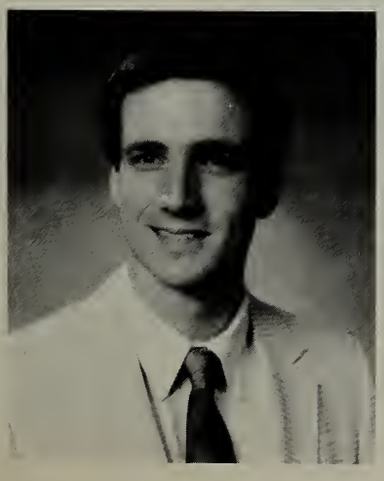
Since that time, this Bellevue family practitioner has continued his involvement in the political scene — in campaigns and as a member of OMPAC.

> ***"Physicians have no right to complain about government intervention if they don't participate."***

"Keeping an open door with local, state and national officeholders can affect the quality of care our patients receive and the style of practice we will be able to carry on," he explains.

The OSMA membership needs to become more involved in all facets of OMPAC — with personal contributions as well as with active participation — but presently the number of OSMA members in OMPAC remains low, Dr. Swedlund says.

"Physicians have no right to complain about government intervention if they don't participate."





Jack L. Summers, MD, Akron

Twelfth District

As a military history buff who collects military miniatures, a certified scuba diver, a creative writer and a gourmet cook, it is difficult to understand how Dr. Summers has time to devote to his practice of urology and his many other medical commitments, much less the time he gives to OMPAC. But Dr. Summers makes the time because he feels the issue is that important.

> ***"We need to have the ear of every politician available."***

"We need to have the ear of every politician available," Dr. Summers says, pointing out that much medical policy is made by people who have no idea of the "current state of medicine."

He is enjoying his venture into politics and recommends it to other physicians. "We need political involvement on all levels — that includes local doctors who can tell us what is happening in their communities."

He says doctors tend to be naive and believe that things like National Health Insurance won't happen here. "Physicians keep thinking the political climate here is different. But it *can* happen here and we must realize that. That's why we must make ourselves heard."



Rose Vesper, New Richmond

OSMA Auxiliary

An OMPAC board member since 1983 and the current campaign chairwoman of the Clermont County Republican Party, Rose Vesper is no stranger to the political environment, having worked on a number of political campaigns over the years.

"If you really want to be effective in the legislative area, you've got to be willing to become involved politically," she explains. "You have to earn the right to sit down at the table and participate in discussions that will determine the future of medicine."

And OMPAC gives physicians the opportunity to take part in these kinds of discussions, she points out. "There's no question that OMPAC opens the door. A legislator has only 24 hours a day. If 20 people are waiting outside the door, and two of the 20 have been involved in the legislator's campaign, the legislator will talk to those two people first," she explains.

> ***"An open door, an honest answer is all we expect. We're not out to buy votes."***

"An open door and an honest answer is all we expect. We're not out to buy votes."



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Financial Planning for Malpractice

By James L. Budros, CFP, ChFC

Most Ohio physicians are concerned about the exposure of their business and family assets in a malpractice claim. Malpractice insurance has been limited and the cost has increased. Indeed, the threat of a malpractice action has become a serious occupational hazard.

While it is not a comfortable thought, it is a legitimate concern to question the safety of one's home, retirement plans, and children's education funds against the claims of a malpractice creditor. There are, however, a number of planning tools which can be utilized to protect family assets. Gifts, trusts, property ownership, life insurance, retirement plans, adequate professional liability insurance and bankruptcy are among the array of possible solutions.

Gifts

Gift-giving prior to a malpractice claim is a legitimate form of family planning if not fraudulent in its intention. The determination of whether a transfer of assets is "fraudulent" or lawful is a question of fact which courts decide in each case after considering a number of factors. If one transfers an asset with the actual intent to remove assets from the claims of creditors, the transfer can be set aside as a fraudulent conveyance. Assume a physician makes a gift of all of his assets that are available for gift-giving to his wife and children. If there are no malpractice suits existing or threatened against him at the time he makes the gift, the physician's transfers would generally not be considered fraudulent and the assets in the ownership of his wife and children would not be subject to the claims of a malpractice creditor. However, assume the physician made a gift of all of his assets to his wife and children, but at the time of his gift he was a defendant in a malpractice action. The fraudulent conveyance rules might embrace the gift if a malpractice suit was in excess of his malpractice insurance coverage. Or it may be considered not to be fraudulent conveyance if the case against the physician was for an amount substantially less than his malpractice insurance.

The understanding of a concept of fraudulent conveyance is critical to a successful gift of assets. The basic idea is that a gift of assets with intent to hinder, delay or defraud a creditor, or at a time when assets are insufficient to meet probable liabilities, is a fraudulent conveyance. The facts always play a critical role in fraudulent conveyance disputes.

There are several things, however, which one can do to increase the likelihood that gifts of assets will not be deemed fraudulent. If one can show estate or income tax reasons for gift-giving, or to provide for children's education, or for the maintenance of an elderly parent, or as systematic birthday gifts, the claim of fraudulent conveyance will be difficult to prove.

The essence of gift-giving is not in who makes the gift or who receives the gift, but the intent of the gift at the time of the gift.

Trusts

Trusts have been used for a variety of reasons ranging from education and support planning, estate management, income and estate tax savings. A trust is a relationship in which assets are transferred to a trustee to be held for the benefit of another. When a person creates a trust, he transfers legal ownership but not beneficial ownership to the trustee. The trustee is bound by law and by the terms of the trust to invest assets and use the income and principal for the beneficiaries.

Gifts in trust are not dissimilar from gifts to individuals and the law of fraudulent conveyance applies. The only distinction is that the donor controls, through the provisions in the trust document, the use of the trust assets, even after the gift. It is clear, therefore, that the maintenance of certain powers over the trust would make the trust assets subject to the claims of creditors. If a trust was revocable or if a trust returned its assets to the donor upon the expiration of a specific period of time, such as in a ten-year Clifford Trust, the assets in the trust might be available for attachment. If, however, the trust is irrevocable and the donor does not maintain substantial control over the assets by being a trustee or through other powers, gifts in trusts should be generally immune from malpractice creditors.

Property Ownership

Most Ohio physicians own their

Naming someone else as the trustee of the retirement fund, investing only "prudently" and designing the plan to cover other employees are tactics to minimize the risk of malpractice exposure.

home with their spouse in the form of ownership called tenancy in common. In tenancy in common each tenant owns an undivided interest in the property without a right of survivorship. Tenancy in common is considered to be an "informal partnership" and the interest of the spouse co-owner should not be subject to the claims of creditors in a malpractice action. Transferring a physician's interest in a tenancy in common in a family home to the physician's spouse can be effective provided the transfer does not constitute a fraudulent conveyance. The best time to transfer home ownership to a spouse is at the time the house is purchased.

Life Insurance

Death benefits under life insurance and the cash value is protected from the claims of creditors by Ohio law. In addition, life insurance can be the subject of gifts to an irrevocable life insurance trust and can, in addition, to further insulate the cash value and proceeds from the claims of creditors, offer substantial estate tax savings.

Retirement Plans

Many physicians will accumulate substantial net worth in retirement plans. Retirement funds are largely exempt from creditor claims under federal law. All tax-qualified retirement plans must contain an alienation provision that the benefits payable to the participants cannot be assigned, attached, alienated or seized by judgment creditors (including malpractice creditors). This law is intended to protect the retirement benefits of participants in qualified retirement plans from having their future financial security jeopardized to pay current obligations. However, since the adoption of ERISA in 1974, there have been a number of cases brought by judgment creditors attempting to attach assets in retirement trusts. In almost all cases, the courts have refused to permit such attachment prior to the retirement of the participant.

In those cases in which retirement funds have been subject to the claims of malpractice creditors, the key factor was the amount of control the physician maintained over the retirement plan assets. For example, if a physician has access to his funds in a retirement plan because he has a right to terminate the plan as the sole shareholder of the sponsoring professional corporation and he withdraws the funds, but at some future date declares bankruptcy, the courts may not exempt the assets in the retirement fund. Naming someone else as the trustee of the retirement fund, not making preretirement use of the funds by extensive borrowing, investing only "prudently" and designing the plan to cover other employees are tactics one should consider to minimize the risk of malpractice exposure.

Individual retirement accounts (IRA) are not protected against the claims of creditors.

Professional Liability Insurance

Given the unpleasant aspects of protecting one's retirement fund, the inconvenience of gift-giving, the complexity of trusts and the onerous thought of bankruptcy, the physician should look carefully at the adequacy of his malpractice insurance. While it may be an expensive option, it may ultimately be the least expensive course of action. Insurance is designed to spread risk where the cost of losing is disastrous by comparison to the cost of the protection. Indeed, no physician should miss the "forest for the trees" in considering the value of medical malpractice insurance as an alternative to the other forms of asset protection that have been discussed.

Bankruptcy

Any physician with severe creditor problems should avoid bankruptcy unless it is the only feasible alternative. The stigma of being bankrupt, the professional's reputation, the loss and use and control of assets are reasons why bankruptcy should be the last resort.

Conclusion

Financial planning for malpractice is a complicated matter. Gifts, trusts, property ownership, life insurance, retirement plans, malpractice insurance and bankruptcy are all tools at the physician's disposal to protect family assets. Not all problems have solutions. A physician concerned about the exposure of personal or family assets to creditors should engage some comprehensive planning for his or her affairs. As always, competent legal advice is necessary.

James L. Budros is a vice-president with SMB FINANCIAL PLANNING, a member of the PICO Financial Services Group which provides specialized financial planning services to physicians and other professional individuals and corporations.

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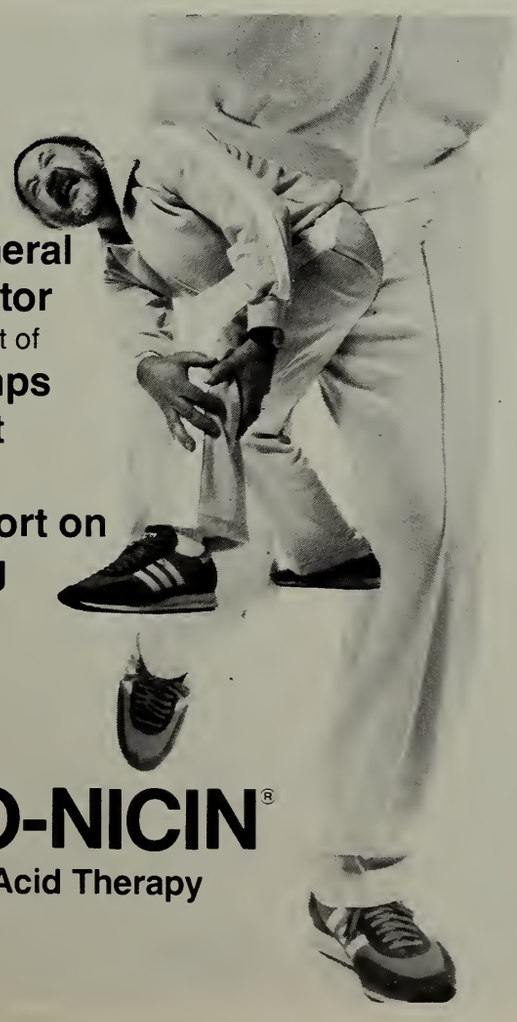
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Proceedings of the Council
July 18-19, 1986

A regular meeting of the Council of the Ohio State Medical Association was held Friday, July 18, and Saturday, July 19 at the Netherland Plaza Hotel, 35 West Fifth Street, Cincinnati, Ohio.

Those present Friday, July 18 were:
John E. Albers, M.D., Cincinnati
D. Ross Irons, M.D., Bellevue
Herman I. Abromowitz, M.D., Dayton
Stanley J. Lucas, M.D., Cincinnati
William J. Marshall, M.D., Dayton
Thomas R. Leech, M.D., Lima
John A. Devany, M.D., Toledo
Donavin A. Baumgartner, Jr., M.D., Cleveland
J. James Anderson, M.D., Youngstown
John F. Kroner, Jr., M.D., Athens
H. William Porterfield, M.D., Columbus
Charles G. Adams, M.D., Vermilion
Joseph L. Kloss, M.D., Akron
Brian F. Jewell, Toledo, President Medical Student Section
Nora Feezel, Canton, President OSMA Auxiliary
Donald R. Goodwin, Columbus, Senior Vice President PICO

Those present from the OSMA staff were:
Herbert E. Gillen
D. Brent Mulgrew, Esq.
Jerry J. Campbell
Robert D. Clinger
Katherine E. Wisse
Gail E. Dodson
David C. Torrens
Carol W. Mullinax
Catherine M. Costello, Esq.
William E. Fry
Carolyn H. Towner
Kent Studebaker
Doug Graff, Esq.
Tom Cashman
Rick Ayish
David W. Pennington

Those present Saturday, July 19 were:
John E. Albers, M.D., Cincinnati
D. Ross Irons, M.D., Bellevue
Herman I. Abromowitz, M.D., Dayton
Stanley J. Lucas, M.D., Cincinnati
William J. Marshall, M.D., Dayton
Thomas R. Leech, M.D., Lima
John A. Devany, M.D., Toledo
Donavin A. Baumgartner, Jr., M.D., Cleveland
J. James Anderson, M.D., Youngstown
John F. Kroner, Jr., M.D., Athens
H. William Porterfield, M.D., Columbus
Charles G. Adams, M.D., Vermilion
Joseph L. Kloss, M.D., Akron
Brian F. Jewell, Toledo, President Medical Student Section
Nora Feezel, Canton, President OSMA Auxiliary
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Thomas J. Halpin, M.D., Columbus, Director Ohio Department of Health
Warren Ljungren, M.D., Dayton, Chairman, Resident Physicians Comm.
Myron Moskowitz, M.D., Cincinnati, Prof. of Radiology, Univ. Hosp.

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William E. Fry
Carolyn H. Towner
Kent Studebaker
Doug Graff, Esq.
Tom Cashman
Rick Ayish
David W. Pennington

President's Remarks

Dr. Albers welcomed the Council to Cincinnati and reviewed the schedule for the meeting. He reviewed his speaking engagements and reported his involvement in the Harvard/AMA Study on Relative Value Scales as a method for reimbursement under the Medicare program.

Dr. Albers reported he had been contacted by several of the Specialty Societies that did not meet the criteria for having representation in the OSMA House of Delegates this year. Dr. Albers appointed the following Ad Hoc Committee of Dr. Irons, Chairman, Dr. Abromowitz and Dr. Leech to study the situation

and to propose solutions to the problem created by the current bylaws.

Assignment of 1986 Resolutions

The Council approved the assignment of resolutions for implementation passed by the 1986 House of Delegates which included the establishment of four task forces — Quality of Care, AIDS Discrimination, High Risk Health Insurance and Capitation System of Reimbursement.

Previous Minutes

The Council approved the minutes of the May 2, 1986 meeting, the May 5, 1986 meeting and the June 10, 1986 telephone conference call meeting.

Executive Director's Report

Mr. Gillen announced that Brent Mulgrew had accepted the position of Chief Executive Officer of the Texas Medical Association and would be leaving the association in mid-September. The Council expressed its congratulations to Brent and thanked him for his efforts on behalf of Ohio physicians for the past 12 years and extended him its best wishes.

Also announced were the resignations of Ms. Toba Cohen and Mrs. Carla Wyckoff of the AMA staff and that Alan Nelson, M.D., Utah, had been elected Chairman of the AMA Board of Trustees.

Mr. Gillen reported that the PRO in Ohio did not get its contract renewed and would go through the rebidding process. He further reported that peer review groups in Michigan and New York have expressed interest in bidding on the Ohio PRO contract.

Mr. Gillen reported the OSMA has been asked to join the Alliance for Tort Reform composed of nearly 70 organizations and groups in Ohio. After discussion, the Council decided to support the efforts of the Alliance but not to authorize the OSMA to join the Alliance. It was the consensus of the Council that the OSMA should remain independent of the Alliance but monitor its activities and that a change in this position rests with the discretion of the Legislative staff.

Mr. Gillen announced that negotiations for the sale of the PACO software were near completion and only a few issues remain to be solved before the books can be closed on PACO.

U. of C. Research Proposal

Myron Moskowitz, M.D., Professor of Radiology at the University of Cincinnati Medical Center, addressed the Council regarding a research proposal to increase the utilization of mammography and breast palpation among women age 50 and over. The Council voted to provide mailing lists for use by Dr. Moskowitz but withheld endorsement of the project.

Legislative Report

Dr. Marshall presented the minutes of the June 25, 1986 meeting of the Committee on State Legislation, and discussed the plans of the committee for the coming year.

Mr. Ayish distributed an analysis of H.B. 974 — Ohio Patient Compensation Fund — and discussed the primary features of the proposed bill. Mr. Ayish also reported on the first hearing on the bill which is sponsored by PICO. The Council voted to take no position on H.B. 974 at this time.

Mr. Ayish provided the Council with a legislative update on all bills of interest currently before the legislature including professional liability and tort reform proposals. He also reported on the activities of the Ohio Health Care Coalition for Professional Liability Reform.

Mr. Ayish discussed the Fall District Legislative Conferences and the need to have greater participation of members and their spouses in OMPAC.

Legal Developments

Ms. Costello distributed and discussed a detailed written report of the legal department's activities regarding administrative rules and four major court decisions that have been decided in the last two months.

Mr. Graff reported on the Annual Meeting of the OSMA Hospital Medical Staff Section. Edmund Jones, M.D., Cincinnati, was elected Chairman for a second term. Gene Feldheimer, M.D., Akron, was elected Secretary-Treasurer. Gus Kious, M.D., Cleveland, was elected to serve as OSMA-HMSS delegate to the 1986 OSMA Annual Meeting with Charles Travis, M.D., Toledo, alternate delegate.

Ohio Delegation Report

Dr. Porterfield, Vice-Chairman, Ohio Delegation to the AMA, presented the report of the Delegation which included the election of Ray Gifford, Jr., M.D., Cleveland, to the AMA Board of Trustees. Dr. Porterfield explained that Dr. Gifford's election was to fill an unexpired term and that he would stand for reelection at the June, 1987 AMA Annual Meeting. Dr. Porterfield reported on the disposition of the resolutions introduced by the Ohio Delegation in the AMA House.

The Council approved the Delegation's "Guidelines for Selecting Candidates from Ohio for AMA Elected and Appointed Positions and Awards."

Auditing and Appropriations Committee Report

Dr. Baumgartner, Chairman, reported the Committee had accepted a draft document of the 1985 financial audit conducted by Coopers and Lybrand.

The Committee discussed Amended Resolution 43-86 — "Funding for Full-time Medical Director, Physician Effectiveness

Program" — which was referred to The Council. The Council approved the following Ad Hoc Committee of Dr. Baumgartner, Chairman, Dr. Devany and Dr. Adams to study Amended Resolution 43-86 and to make recommendations to the Council for implementation.

On recommendation of the Committee, the Council authorized an expenditure of $2,500 toward funding administrative and implementation costs of the AMA Health Policy Agenda.

The Treasurer's report was approved as presented.

The Council approved the Committee's recommendations on certain budget adjustments for 1986.

Committee Reports

The Council accepted for filing the following Committee minutes:
Committee on Education, April 8, 1986
OSMA-OOA-ONA Liaison Committee, March 12, 1986
Committee on Maternal and Neonatal Health, April 20, 1986

The Council approved a resolution from the OSMA/Medical Student Section calling for certain changes in the bylaws of that organization.

The Council referred to the OSMA Committee on Impaired Physicians a resolution titled "Impaired Health Providers," developed by the OSMA/MSS.

Group Professional Liability Policy

Mr. Goodwin, Senior Vice-President of PICO, reviewed proposed changes in the OSMA Group Professional Liability Policy. Several questions were raised concerning exclusions in the policy. After discussion the Council voted to refer the proposed policy back to the PICO Underwriting Committee for reconsideration and granted the authority to the officers to make the final decision on the terms of the new policy.

Medical Board

Ms. Costello reported the Ohio State Medical Board is considering the development of public service announcements which would ask the public to contact the local county medical society on matters regarding physician fee complaints. Inasmuch as most county medical societies do not conduct fee reviews, the Council voted to file an objection with the Board concerning this matter.

Ms. Costello reported the Medical Board is giving consideration to a policy statement regarding who can conduct histories and physicals in outpatient surgical facilities. The Council voted to communicate to the Board the OSMA position that histories and physicals are a part of the practice of medicine and should be conducted by physicians.

Ms. Costello stated the Medical Board has established a policy of requiring all physicians to submit their CME logs when they are more than 30 days late in renewing their license. The Council voted to ask the Board to reconsider this action and expressed its willingness to discuss with the Board alternatives to this action.

The Council asked that minutes of the Medical Board be forwarded to the Council when received by the OSMA.

The Council was presented with details of a case decided by the Medical Board involving a Lima physician. Dr. Albers and Dr. Leech discussed a request from the Academy of Medicine of Lima and Allen County for the OSMA to become involved in this case.

The Council authorized the officers to file an amicus brief in this case when appropriate after review and recommendation of the legal department.

Auxiliary Report

Mrs. Nora Feezel, President of the OSMA Auxiliary, presented a written report of the Auxiliary's activities and highlighted the honor received from the AMA Auxiliary for 100% participation in the AMA-ERF. Mrs. Feezel also reported on the smokeless tobacco program in Ohio schools.

Health Director's Report

Dr. Thomas Halpin, Interim Director of the Ohio Department of Health, addressed the Council on several issues. He reported that 188 cases of AIDS have been identified in Ohio as of the end of May, most of whom are gay or bisexual. Dr. Halpin stated there are approximately 30,000 to 40,000 in Ohio infected with the AIDS virus and that it costs approximately $147,000 to treat an AIDS case.

Dr. Halpin also discussed the Health Service Corps situation in Ohio, infectious waste disposal, day-care rules and the probability that funds for health planning would soon run out.

Councilor Reports

Reports were given by Councilors highlighting current activities in the various councilor districts.

The Council voted to support the nomination of Theodore Castele, M.D., Cleveland, for the AMA Benjamin Rush award.

The Council voted to have the Committee on Membership to reconsider the phonathon for recruiting new members and to reconsider a joint membership for married physician couples.

The Council also discussed concerns that have been raised regarding organ procurement versus organ donation.

It was announced that the Greene County Medical Society would be celebrating its 100th anniversary this year.

The Council approved a resolution for submission at the AMA Interim Meeting in December on working with producers of movies and programs for television on how smoking is portrayed.

Personal Privilege

Mr. Mulgrew asked for a point of personal privilege and thanked the Council for its support of his efforts the past 12 years.

Meeting adjourned.

Respectfully submitted,
Herbert E. Gillen
Executive Director

We're Looking for Contributors . . .

This year, why not become a contributor as well as a reader of The Ohio State Medical Journal? We can always use "Second Opinions," "Essays" and "Letters to the Editor."

Obituaries

WILLARD D. BOAZ, MD, Cleveland; University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania, 1945; age 65; died July 24, 1986, member OSMA and AMA.

ANDREW V. BOYSEN, MD, Elyria; Ohio State University College of Medicine, 1959; age 57; died August 11, 1986; member OSMA and AMA.

C. DOUGLASS FORD, MD, Toledo; New York Medical College, New York, New York, 1949; age 62; died July 19, 1986; member OSMA and AMA.

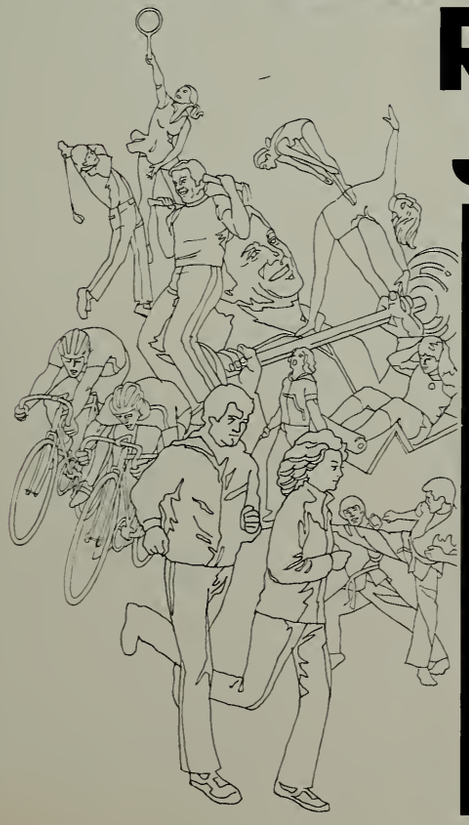
HARLEY HAYNES, JR., MD., Akron; University of Michigan Medical School, Ann Arbor, Michigan; age 77; died July 29, 1986; member OSMA and AMA.

EDWARD W. KISSEL, MD, Birmingham, Alabama; Loyola University Stritch School of Medicine, Maywood, Illinois, 1938; age 73; died August 1, 1986; member OSMA and AMA.

HOYT B. MEADER, MD, Hamilton; Toledo Medical College, 1913; age 95; died July 26, 1986; member OSMA and AMA.

LASZLO SZENTENDREY, MD, Cleveland; Orvosi Fakultas Tudomanyegyetem, Budapest, Hungary, 1927; age 83; died July 12, 1986; member OSMA and AMA.

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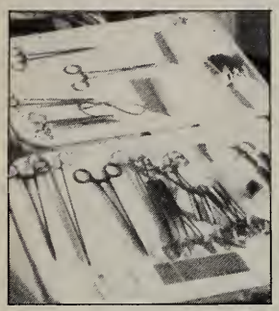
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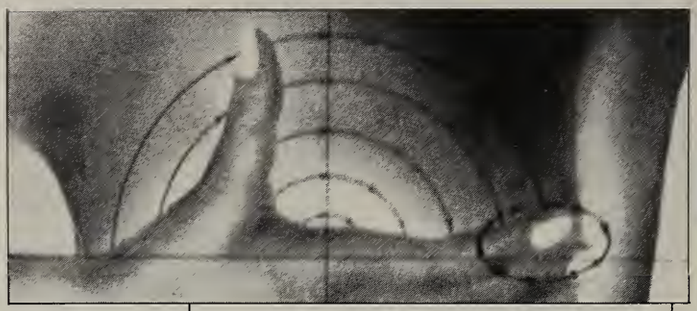
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Continuing Medical Education Calendar







October

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CINCINNATI CANCER CONFERENCE V: BREAST CANCER: October 31 and November 1; Westin Hotel, Cincinnati; sponsor: Bethesda Hospital; 9 credit hours; fee: $200; contact: Tom O'Connor, Bethesda Hospital, 619 Oak Street, Cincinnati 45206, phone: 513-569-6339.

November

CARCINOMA OF THE BREAST: November 5; Lancaster-Fairfield Community Hospital; sponsor: American Cancer Society; 4.5 credit hours; fee: $50; contact: Medical Staff Secretary, Lois A. Bauman, Lancaster-Fairfield Community Hospital, 401 North Ewing Street, Lancaster 43130, phone: 614-687-8177.

CARDIOVASCULAR RISK FACTORS — IDENTIFICATION, EVALUATION & MANAGEMENT — UPDATE 1986: November 6; Holiday Inn, Troy; sponsor: Dettmer Hospital; jointsponsors: American Heart Association, Ohio Chapter, and Wright State University; 6 credit hours; fee: $60, $30 for others; contact: Gerard F. Wolf, MD, 145 N. Sunset Drive, Piqua 45356, phone: 513-773-8323.

COLORECTAL SURGERY SYMPOSIUM: November 7-8; Bunts Auditorium, Cleveland Clinic; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: $190; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

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MANAGEMENT OF ASYMPTOMATIC CAROTID DISEASE

B. Mohan Das, MB, BS
Bhagwan Satiani, MB, BS, FACS

There are 20 million people in the United States between the ages of 65 and 80 years. One million of them harbor an asymptomatic carotid bruit. Strokes continue to be the third leading cause of death in this high risk age group.

We recommend serial noninvasive studies to evaluate, follow and categorize these asymptomatic patients into high and low risk groups. We advocate surgery in good risk patients with high grade stenosis (>75% stenosis). The surgeon's operative stroke rate should be less than 3% in asymptomatic patients.

There is perhaps no issue in vascular disease that is as controversial as management of the patient with an asymptomatic carotid bruit. It is estimated that an asymptomatic carotid bruit is present in four percent of the population over the age of 50, and in five percent of the population over the age of 60. There are at present 20 million people in the United States between the ages of 65 and 80. Hence there may be as many as one million people with a cervical bruit. It is further estimated that the incidence of new cervical bruits in the remaining 19 million is one percent per year, which would account for a further 190,000 to be added to this growing pool. Strokes continue to be the third leading cause of death, behind heart disease and cancer. A recent study indicates it may have been relegated to fourth place, replaced by trauma as the third leading cause of death. Epidemiological studies show that the incidence of stroke is declining, due at least in part to better control of hypertension and other risk factors. In 1980 there were 170,000 stroke-related deaths, and 240,000 new strokes in people over the age of 65. The cost of stroke care in the United States in that year alone was 5.1 billion. There is concern with the increasing number of carotid endarterectomies performed in the U.S. In 1971, there were 15,000 carotid endarterectomies performed in the United States. In the last decade, this figure has escalated to 85,000 procedures in 1982!

Most of the controversy stems from the fact that there is a paucity of information on the natural history of cervical carotid disease and about asymptomatic bruits. The angiographic study by Javid et al[2,3] done in the early 1970s documents progression of the carotid bifurcation plaque in two-thirds of patients. Thompson et al have also documented progression of cervical carotid atherosclerosis and recommended surgery for asymptomatic lesions.[4] A more recent duplex scan study from Seattle supports this concept,[5] as does another independent study from Toronto.[6]

Less than 10% of all strokes are preceded by TIAs (Transient Ischemic Attacks). About one-third of all strokes are probably carotid-related (80,000 of the 260,000 strokes in 1980). However, 45% of those with a carotid lesion will probably have a TIA. Therefore, greater than 50% of carotid-related strokes will not have a warning in the form of a TIA prior to a stroke. Therein lies the crux of the problem. If there was some way by which the patients with carotid-related strokes could be identified early, one could selectively recommend repair of those potential stroke-causing lesions. Noninvasive studies offer some help in this regard. If every cervical bruit was worked up with a single noninvasive test at $200 apiece, then the total cost would amount to $200 million, and workup of an additional 190,000 new bruits would average about $3.8 million per year. This, when compared to the cost of stroke care of $5.1 billion in 1980, is still small by comparison.

With the many noninvasive devices currently available to study carotid disease, there is some confusion regarding management of patients with newly discovered carotid stenosis of varying degrees. Our own approach, which we feel is reasonably conservative, and one which individualizes each patient, is presented. We acknowledge the fact that there may be many readers who may be more aggressive, and even some who prefer a more conservative approach.

Asymptomatic Bruit

Let us first approach the problem of the patient with an

From the Department of Surgery, Grant Medical Center, Columbus, Ohio.

Table I

AUTHORS	# PTS	FOLLOWUP MONTHS	CRITERIA	TIA %	STROKE %	CEREBRAL EVENT% (TIA, STROKE, OR TOTAL OCCLUSION)
Kartchner & McRae 1977	1024	70	OPG/CPA Positive (147)		11.9	
			OPG/CPA Negative (866)		1.9	
Thompson et al 1978	138	184	Bruit only	26.8	17.4	
Dorazio et al 1980	97	156	Bruit only	11	19	
Busuttil et al 1981	73	30	OPG-Gee > 60% stenosis	28.9	6.6	
			< 60% stenosis	7.1		
Roederer et al 1984	162	36	Duplex scanning < 80%			35 @ 6 months
						46 @ 12 months
			< 80%			1.5 @ 6 months
Chambers et al 1984	500	30	< 75% stenosis			15 per year
			< 75% stenosis			3 per year

Legend: CPA — Carotid Phonoangiography
OPG — Oculoplethysmography

asymptomatic carotid bruit. A cervical bruit is nothing more than a "noise" in the neck, and its significance has to be determined. Venous hums can be obliterated by firm, gentle pressure exerted by the diaphragm of the stethoscope and vary with the respiratory cycle. Cardiac murmurs and lower cervical bruits that get fainter as they are traced upward are of less critical import.

Bruits that are heard in the supra and infraclavicular regions but which fade away in the upper neck probably originate in the ipsilateral subclavian or axillary artery. In a patient with subclavian bruits, questions can be directed toward symptoms such as arm fatigue and vertebrobasilar symptoms such as dizziness, syncope, and diplopia, especially with the use of the arm. If the patient has symptoms suggestive of subclavian stenosis or steal, then bilateral arm blood pressures can be obtained before and after exercise to see if the symptoms can be reproduced or to document inequality of the blood pressure in the arms. If symptoms can be reproduced then these patients merit further workup. In the absence of symptoms but presence of unequal arm pressures, they should be advised of the possible existence of a subclavian lesion that needs careful followup. They should be forewarned of the possible symptoms that could develop, which would then dictate a more vigorous approach. Carotid noninvasive studies should be obtained for future comparison.

Careful palpation of the cervical area to rule out cervical ribs and close inquiry into any trauma is merited. If a cervical rib is suspected a chest x-ray may be obtained. If the physician notices signs of upper extremity ischemia or embolic phenomena in association with a supra/infraclavicular bruit, then the possibility of a subclavian aneurysm should be seriously entertained.

After a detailed history and thorough physical examination, including careful auscultation, venous hums and cardiac murmurs are eliminated, and one is then left with a mid or high cervical bruit of carotid origin. If on auscultation the bruit possesses a diastolic component, then a significant internal carotid lesion exists.

Once the presence of a mid or high carotid bruit is established, one should ascertain that it is indeed "asymptomatic." The patient should be questioned in detail for hemispheric, ocular and vertebral basilar symptoms. It is not uncommon to find an appreciable number of patients who are not truly "asymptomatic"; gentle and firm prodding of their memory often reveals significant previous symptoms. If these patients are eliminated, then we are left with truly asymptomatic patients.

The next step is to ascertain the hemodynamic significance of the carotid bruit. There are a number of noninvasive vascular tests to evaluate the carotid bruits, including direct tests (B Mode scanning, Duplex scanning) or indirect tests (oculoplethysmography, doppler exam, Echoflow® etc.) Whatever the noninvasive method selected, it should be fairly accurate and reproducible. At our institution we use the Echoflow® and Duplex scanning (doppler with real time imaging) and have been quite satisfied with the results, with an accuracy of about 85-90% compared to angiography.

Once a baseline noninvasive study has been obtained, it is prudent to use the same study for subsequent followup examinations so that subtle changes and disease progression can be serially documented. Recent studies indicate that the duplex scanner is probably more useful in following progress of noncritical lesions that are not detected by other methods.

When a positive noninvasive study has been obtained, the term "asymptomatic carotid bruit" should be replaced with the term "asymptomatic carotid stenosis." Several studies in the past have documented the fact that the incidence of stroke in an asymptomatic bruit is on the order of 1-2% per year. Both the Evans County study[7] and the Framingham study[8] showed there was an increased incidence of stroke, but only 30% were ipsilateral to the lesion. They concluded that cervical bruits were just markers of generalized atherosclerosis and, furthermore, pointed out that these people were also at a high risk for coronary events, especially if they were males with hypertension. Unfortunately, these studies looked at the population as a whole and no effort was made to differentiate between hemodynamically significant lesions and insignificant ones. Barnes,[9] Kartchner and McCrae[10] have shown that there is up to a 17 fold increase in the stroke rate in people with hemodynamically significant lesions, while the incidence of stroke in those without such lesions was less than 2%.

Two recent studies, one from Toronto[6] and the other from Seattle,[5] are worth reviewing in this regard. The Toronto asymptomatic bruit study examined 500 people and followed them for a mean of 30 months. In this group there were 28 ischemic events in 25 patients. Twenty-two of 28 events were appropriate to the site of the stenosis. There were five frank strokes. The most significant finding was that the risk of a neurological event (TIA, stroke, total occlusion) was 15% per year for those with >75% stenosis, and 3% per year for those with <75% stenosis.

The Seattle group studied 1,450 people, of whom 203 were found to have asymptomatic cervical bruits. One hundred sixty-two were available for the study, and they were followed for an average of three years. All strokes occurred in patients with >80% stenosis, and five of six TIAs occurred in patients with >80% stenosis. Among the people with >80% stenosis, the risk of occlusion, stroke or TIA was 35% at six months and 46% at one year. In striking contrast, in patients with <80% stenosis, the stroke rate was <1% at six months.

So the inevitable conclusion from these two recent studies and from several older studies (Javid, Barnes, McRae et al[2,9,10]) is that carotid stenosis does progress in a significant number of patients. Those with hemodynamically significant lesions (>75% stenosis) are definitely at greater risk for a neurological event or total occlusion (Table 1). In general, all patients with asymptomatic carotid disease should have other risk factors, i.e. hypertension, lipoprotein abnormalities, etc., controlled.

Management

Asymptomatic patients with <50% stenosis can be followed by semiannual noninvasive studies. Should the lesion progress to >75% stenosis, they should then be considered for arteriography and surgery, unless they have other risk factors that would exclude them as surgical candidates, or if their life expectancy is limited. If at any time during the followup period these patients become symptomatic, then they would merit an arteriogram. If an appropriate carotid lesion is found on the contrast study, they should then undergo surgical repair.

Patients with asymptomatic, >50% stenosis but <75%, should be followed fairly closely, especially if they are under 65 years of age. They should get a noninvasive study every four months for about one year and then semiannually. Should the lesion progress to >75% or symptoms occur, they should also be considered for arteriography and elective surgery. If the initial noninvasive test indicates a >75% stenosis, with no significant cardiac or other risk factors, then angiography and repair should be discussed (Algorithm).

The surgical option is attended with some risks. The oft-quoted acceptable surgical stroke rate for asymptomatic bruits is less than 2%.[4] However, a recent study from Cincinnati[11] and an older study from Springfield, Illinois[12] show a much higher incidence of perioperative morbidity and mortality with carotid surgery in general. In 1980 in the Cincinnati metropolitan area, 47 surgeons from 16 hospitals performed 431 carotid procedures. The operative stroke rate was 8.6%; 50% of the endarterectomies were done for asymptomatic bruits. The stroke rate for asymptomatic patients was 5.6%, and for symptomatic patients, 11.6%. The city-wide experience in Springfield consisted of 228 operations with a perioperative stroke and death rate of 21.1%. These are inordinately high figures.

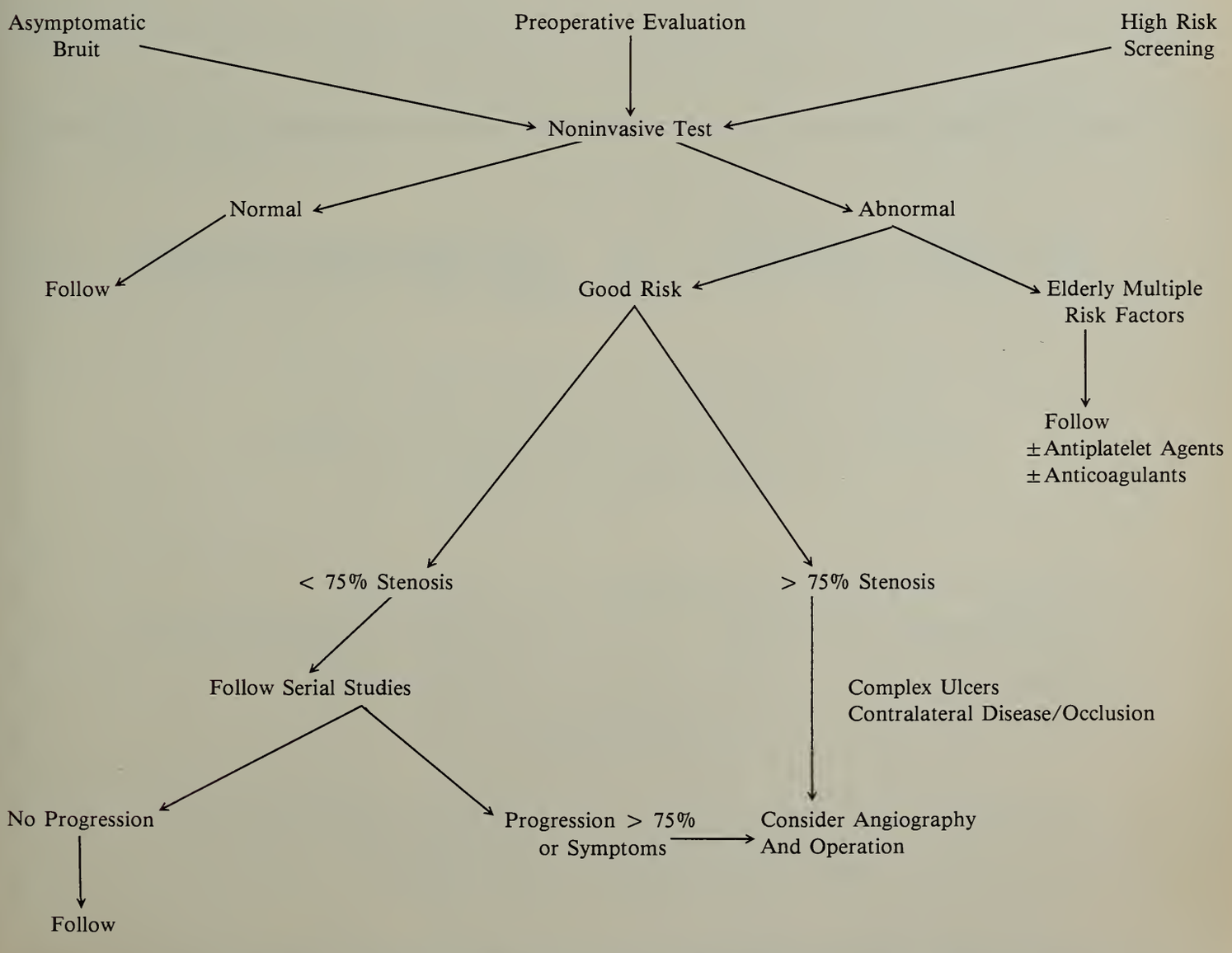
The surgeon who operates on asymptomatic bruits should strive for a stroke rate of under 3%. This equation should be taken into consideration when recommending the surgical option to the patient. If well trained surgeons, skilled in this type of vascular procedure, are available, then the surgical option merits serious consideration. If, however, such expertise is not available, then they should either be referred to centers where such expertise is readily available or else treatment with anticoagulants or long-term antiplatelet agents can be utilized.[13,14] If a patient experiences symptoms while on these medications, then serious consideration should be given to angiography and repair.

Summary

An asymptomatic carotid bruit is prevalent in 5% of the population over the age of 65. Such patients are best evaluated by serial noninvasive studies to separate them into those who are

Algorithm

ASYMPTOMATIC CAROTID BRUIT



at high risk for a neurological event (>75% stenosis) and those who are at low risk (<75% stenosis). If they are reasonable surgical candidates, then they should undergo arteriography and surgery. If they have other co-morbid states that preclude them as surgical candidates, then anticoagulation or antiplatelet agents should be considered. The surgeon who operates on asymptomatic patients should be well trained and strive for a stroke rate of less than 3%.

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Next Month in

THE Ohio STATE Medical Journal

How Ohio hospitals are coping with their problems.

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hydrocodone bitartrate 5 mg (Warning: May be habit forming.)
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INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
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Drug Abuse and Dependence: VICODIN is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
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Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
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Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
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Pediatric Use: Safety and effectiveness in children have not been established.
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Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
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Revised, April 1982.

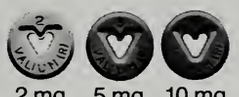
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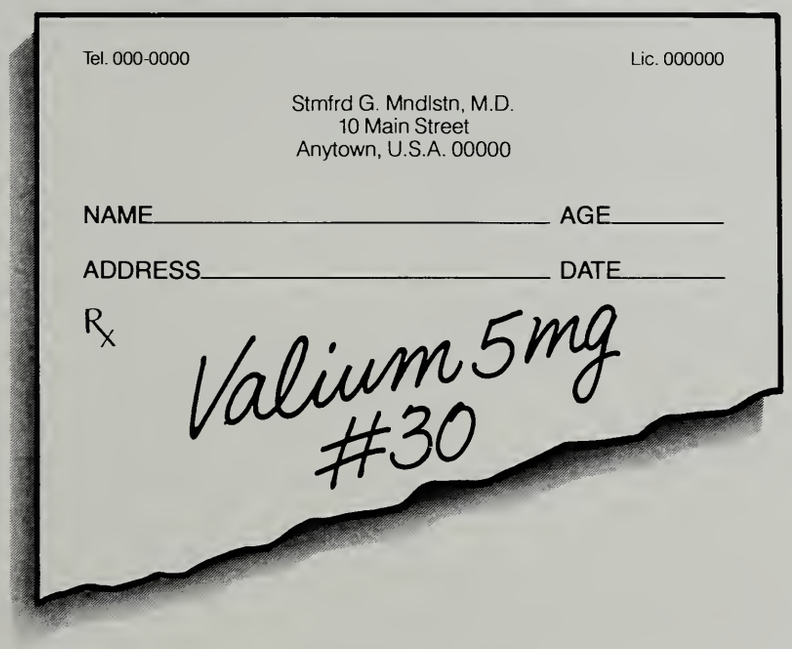
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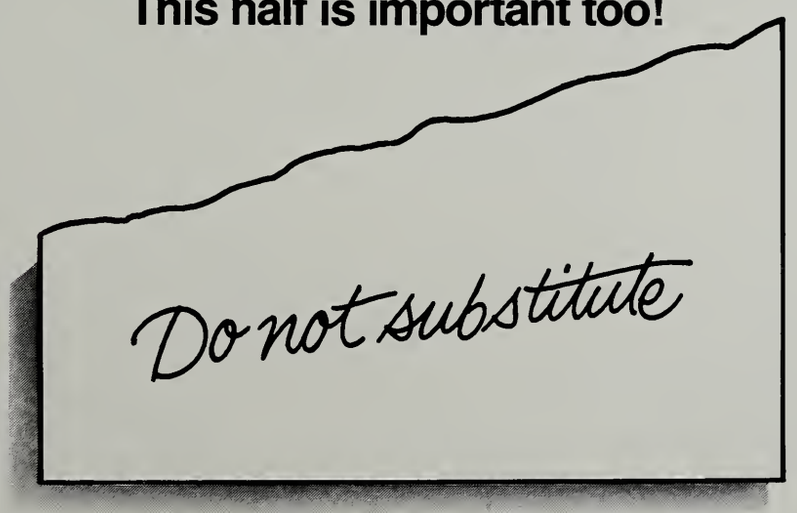
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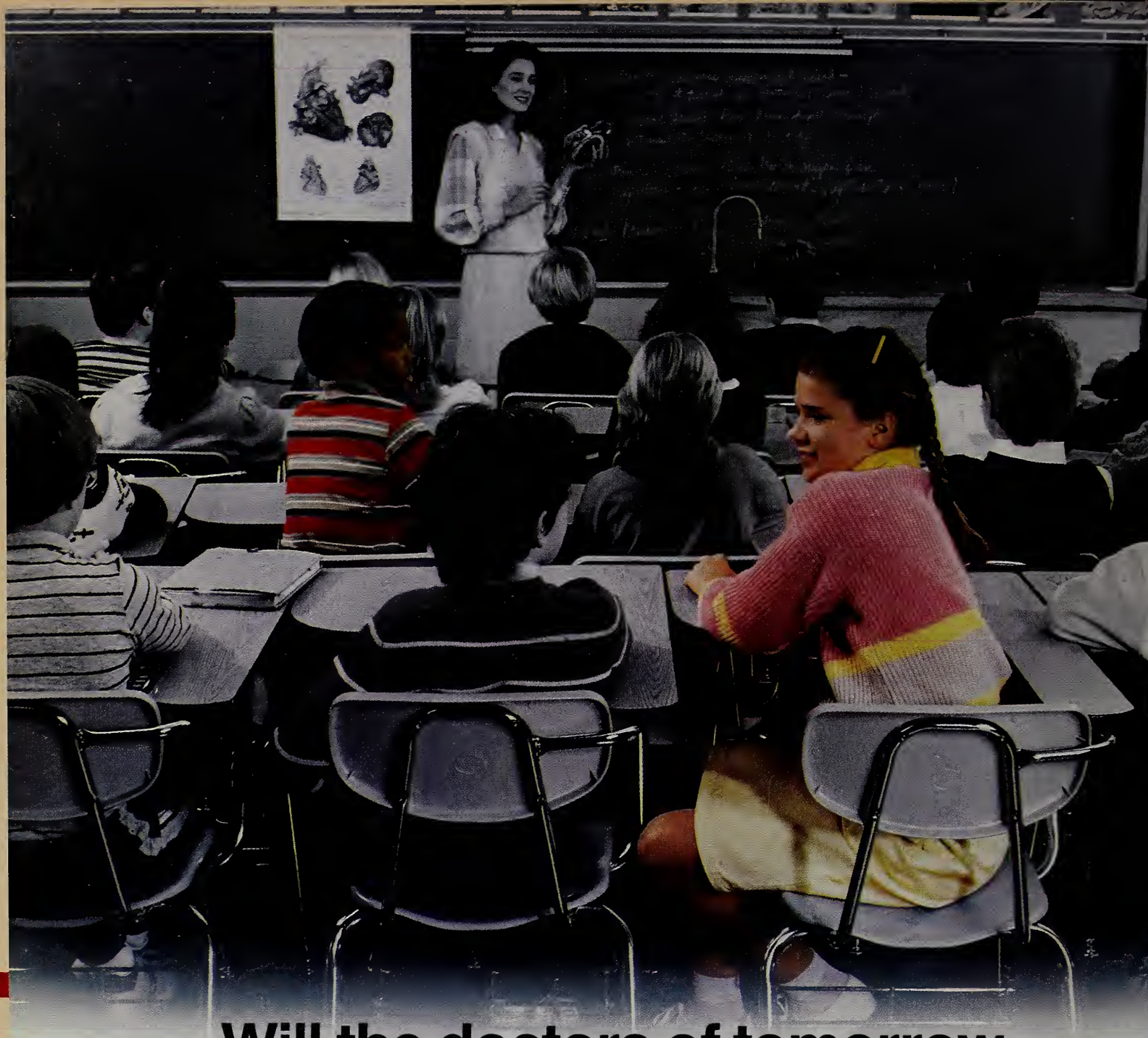


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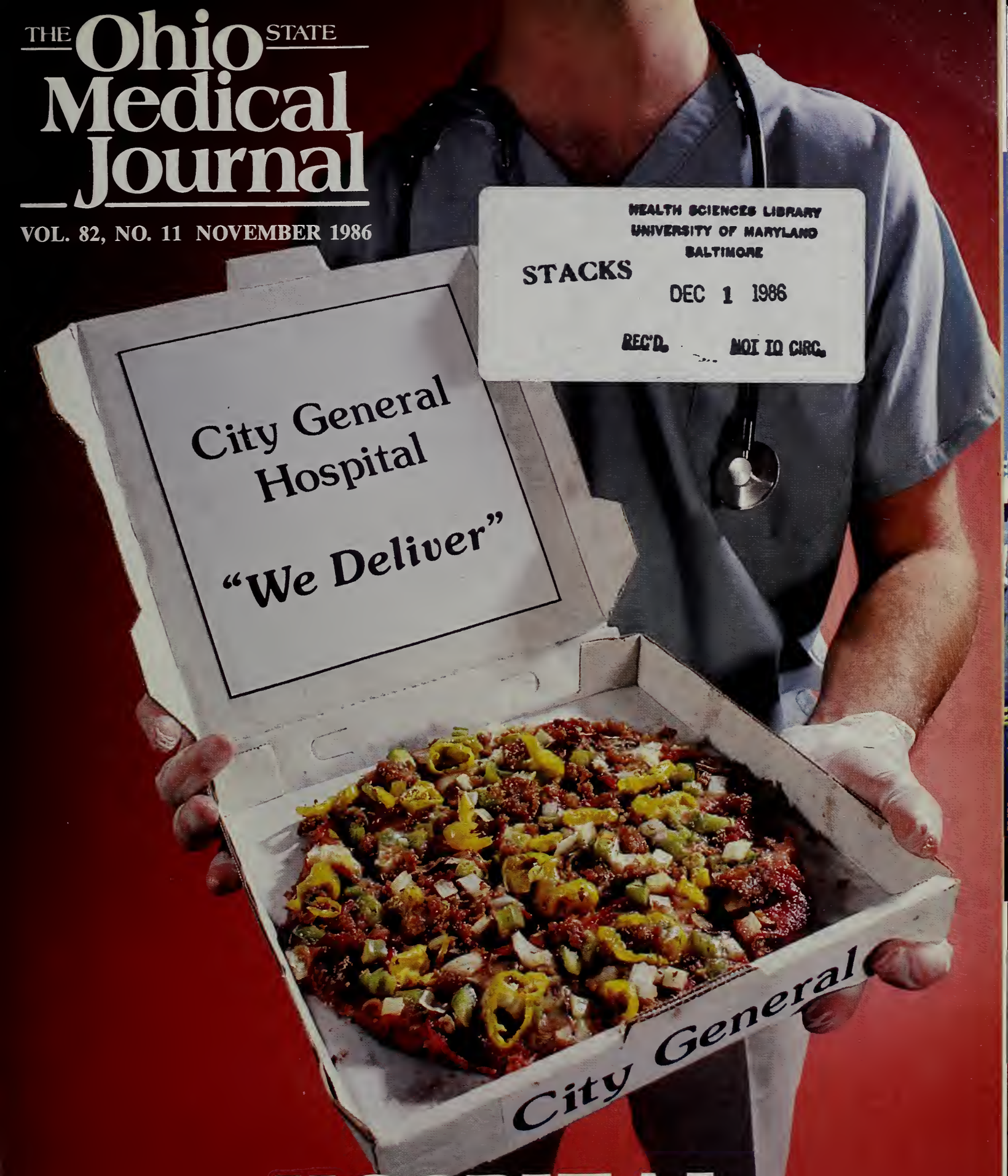
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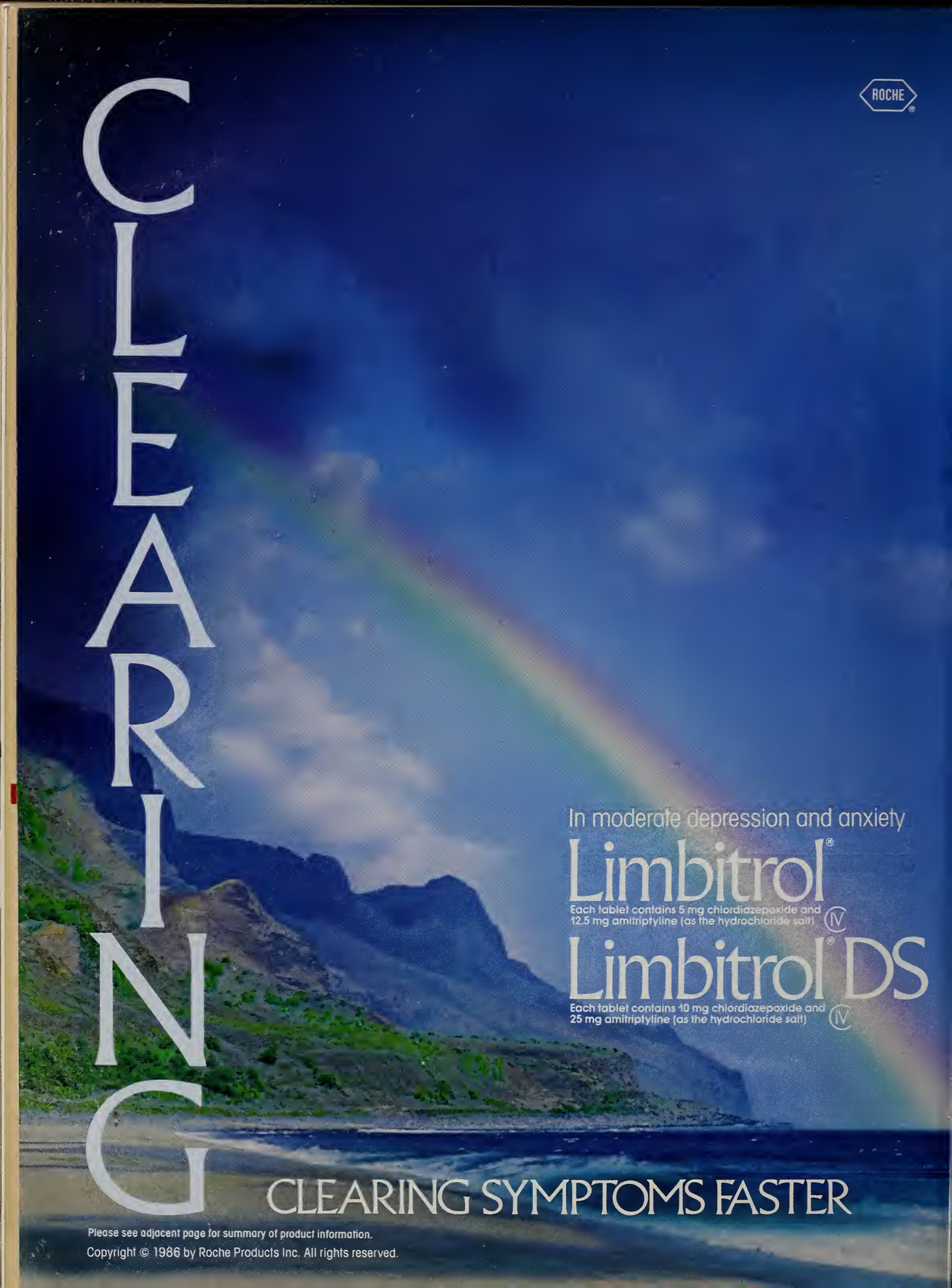
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LIMBITROL* Ⓥ **Tranquilizer-Antidepressant**
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neuralgia: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematalagic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles of 100 and 500; Tel-E-Dose* packages of 100; Prescription Paks of 50.

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FROM THE EDITOR

Hospital marketing . . . an idea whose time has come, or gone too far?

Ten years ago, there probably wasn't a doctor in practice who really believed that health care marketing would get off the ground. It was ridiculous — preposterous! Who could imagine a physician — much less a hospital — advertising its services? No, the garish four-color print ads; the models with perfect teeth pitching products in front of television cameras were all well and good for toothpaste, used cars, power drills and burial plots, but medicine was too — well — *dignified* for that kind of three-ring circus!

But times change — and so did health care's competitive environment. The GMENAC report which predicted an oversupply of physicians by 1990 seemed (and still seems) to be right on target — and with the institution of DRGs, hospitals suddenly faced the prospect of an awful lot of empty hospital beds to fill. As a result, doctors and hospital administrators *both* began to take a new look at marketing and advertising services which, before, depended only on word of mouth.

For better or worse, then, health care marketing has rapidly become a fact of life in the profession — albeit a far-from-comfortable one for a number of health care professionals. Of course, there are those who love it — but there are also those who think of it as a "necessary evil," and still others who think there is nothing "necessary" about it. It's not really caught on, yet, with a majority of physicians — but hospitals have taken to it like first-graders to peanut butter and jelly sandwiches (let one child begin to pack them, and soon the whole school is doing it).

This month, Associate Editor Susan Porter takes a look at hospital marketing — why they have chosen to advertise, the results they're seeing — and how far they intend to go. Assistant Editor Deborah Athy follows up with a look at the present marketing programs of some Ohio hospitals.

Also in this issue, a senior researcher at the Comprehensive Cancer Center at Ohio State University presents an informative look at cancer mortality rates and trends in the state — for both whites and non-whites — and this month's "Ohio Medi-scene" explores such subjects as "The Business of Medical Societies" and a new organization which supports aging research here in Ohio.

Don't forget that we are always looking for contributors, sources, even readers with unusual hobbies, so if you would like to participate in the *Journal,* please let us know. We'd love to hear from you — and share your talents with our readers!

Karen S. Edwards

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☐ Thursday, November 6
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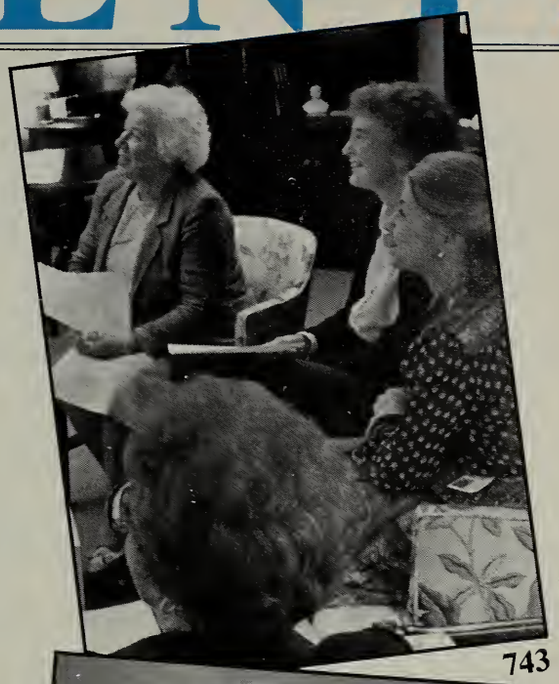
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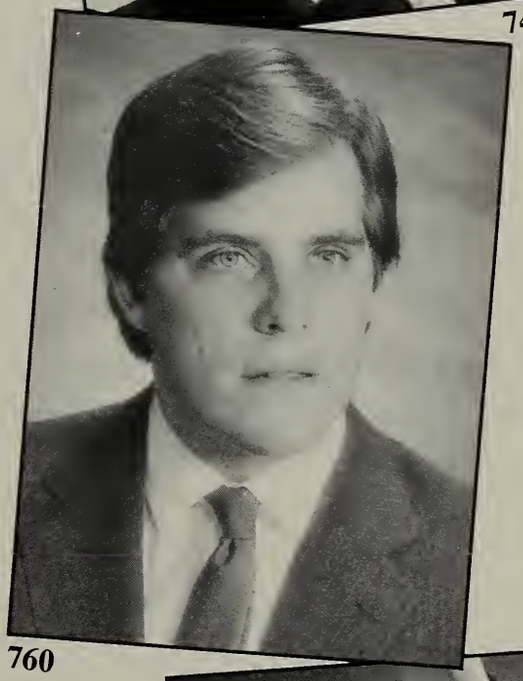
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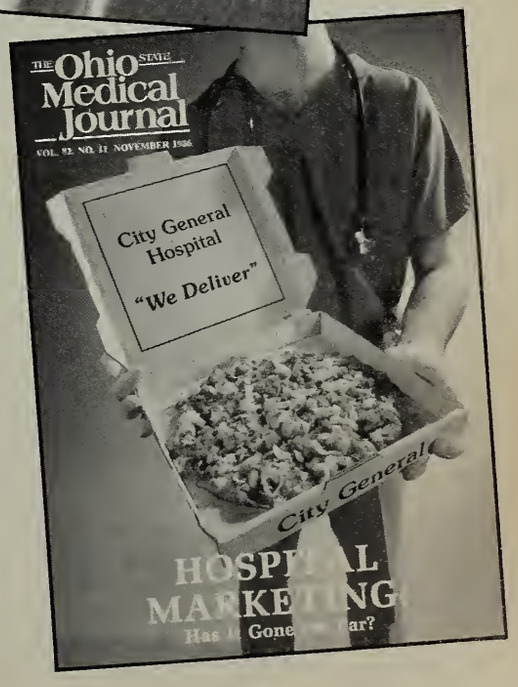
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I certify that the statements made by me above are correct and complete.

Karen S. Edwards, Executive Editor

THE Ohio STATE Medical Journal

EDITORIAL STAFF

Executive Director
Herbert E. Gillen
Director, Department of Communications
Carol Wright Mullinax
Executive Editor
Karen S. Edwards
Associate Editor
Susan Porter
Production Assistant
Cindy Wolfe
Assistant Editor
Deborah Athy

ADVERTISING

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In Memoriam

To the Editor:

We all know that memories can be short, but I can't let this lapse go by without comment. In the August issue of the *Journal* on page 559 (Obituaries) at the bottom of the page is a short little item reading "Merrill D. Prugh, M.D., Dayton; Hahnemann Medical College of Philadelphia, 1909; age 102, died May 24, 1986; member OSMA and AMA."

This delightful, lovable gentleman deserves more recognition than a bare notice at the bottom of the page that he was a member of OSMA and AMA.

Dr. Prugh was a surgeon for years in Dayton and not only was he councilor of the 2nd District of OSMA, he was a past president of our organization, a position he held most ably. He was well liked and personified what was best in a profession to which he was proud and happy to devote his energies. I never knew anyone who didn't like and respect Merrill Prugh and the high ideals he lived for. I wish there were more like him today.

The practice of medicine has lost a loyal adherent and I consider myself fortunate to have been able to follow in his footsteps.

Yours most sincerely,
Edwin H. Artman, MD
President OSMA, 1960
Sun City Center, FL

A new Journal

To the Editor:

I was extremely pleased with the August issue of *The Ohio State Medical Journal.* It looks great and the articles were of extremely high caliber from the Ohio Medi-Scene through the Departments. I found the issue to be interesting, informative and well worth my time.

Proofreading remains a problem for all publishers, and I did notice a few typographicals in the course of my reading. The overall effect though was that of a brand new journal with an exciting exterior and substance to match within the covers.

Sincerely,
Frank E. Foss, MD
Toledo, Ohio

Corrections

• In an article entitled "Organ transplants — an update" which appeared in the August issue of the *Journal,* it was erroneously reported that "House Bill 770, which passed in the Ohio Senate earlier this year, would require that all Ohio hospitals solicit donations in case of brain death."

In fact, House Bill 770, sponsored by State Representative Ronald Suster (D-Cleveland), would require hospitals to establish protocols to set forth under what circumstances requests for organ and tissue donations could be made. This bill has passed the House of Representatives and is currently in the Senate Rules Committee. Action on this bill is not expected by the Senate until November 1986.

• Last month's "County Society Roster Changes" omitted the following information:

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WHY AMA?

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PRECAUTIONS

General. *CARDIZEM (diltiazem hydrachlaride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given aver pralanged periods, laboratary parameters shauld be manitared at regular intervals. The drug shauld be used with cautian in patients with impaired renal ar hepatic function. In subocute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were assaciated with hepatic damage. In special subacute hepatic studies, arol doses of 125 mg/kg ond higher in rats were assaciated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepotic chonges; however, these changes were reversible with continued dosing.*

Drug Interaction. *Phormocologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest thot concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and o 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacteriol tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been canducted in mice, rats, and rabbits. Administration of dases ranging from five to ten times greater (an a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These dases, in some studies, have been reparted to cause skeletal abnormalities. In the perinatol/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was on increased incidence of stillbirths at doses of 20 times the human dase ar greater.*

There are na well-contralled studies in pregnant wamen; therefare, use CARDIZEM in pregnant wamen anly if the potential benefit justifies the potential risk ta the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One repart suggests that cancentrations in breast milk may appraximate serum levels. If use af CARDIZEM is deemed essential, an alternative methad af infant feeding shauld be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Seriaus adverse reactians have been rare in studies carried aut ta date, but it shauld be recognized that patients with impaired ventricular function and cardiac canductian abnormalities have usually been excluded.

In damestic placeba-cantrolled trials, the incidence af adverse reactians reparted during CARDIZEM therapy was nat greater than that reparted during placeba therapy.

The fallawing represent occurrences abserved in clinical studies which can be at least reasanably assaciated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been estoblished. The most common occurrences as well as their frequency of presentotion are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), brodycardia, congestive heart failure, flushing, hypatension, palpitatians, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipatian, diarrhea, dysgeusia, dyspepsia, mild elevatians af alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vamiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, phatosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, palyuria, sexual difficulties.*

The following postmarketing events have been reparted intrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

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References: 1. *Pepine CJ, Feldman RL, Hill JA, et al: Clinical autcame after treatment af rest angina with calcium blockers: Comparative experience during the initial year af therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983; 106(6):1341-1347.* ***2.*** *Shapiro W: Calcium channel blockers: Actians an the heart and uses in ischemic heart disease. Consultant 1984;24(Dec):150-159.* ***3.*** *Johnstan DL, Lesaway R, Humen DP, et al: Clinical and hemodynamic evaluatian af prapranalal in cambinatian with verapamil, nifedipine and diltiazem in exertianal angina pectaris: A placebo-cantralled, dauble-blind, randamized, crassaver study. Am J Cardial 1985;55:680-687.* ***4.*** *Cahn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook af Cardiavascular Medicine, ed 2. Philadelphia, WB Saunders Ca, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blackers in ischemic heart disease: When ta use which. Mad Med 1982;50(Sept):94-116.*

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AIDS — A Practitioner's View

By J. Nicholas Gordon, MD

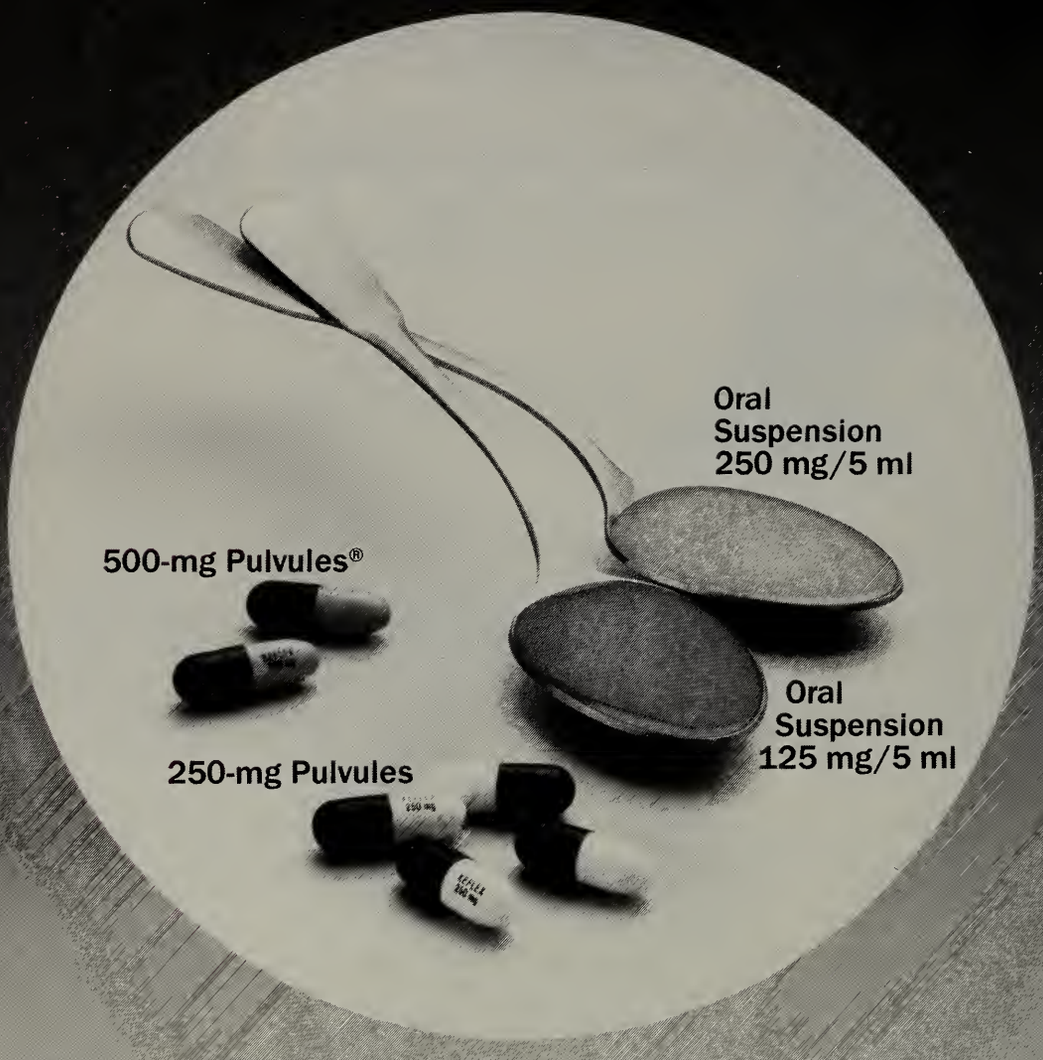
I have always had the greatest respect for CDC and the United States Public Health Services. CDC has done outstanding work in the fields of epidemiology and infectious disease and I can think of no organization that has done more to promote and foster the health and welfare of the people of the United States than the U.S. Public Health Service. I cannot, however, accept their policies and recommendations in regard to AIDS. I did not write this outline to ridicule or discredit the above mentioned excellent organizations or to become a "folk hero." I wrote this outline as a matter of conscience.

Dr. June Osborn, Dean of the School of Public Health at Michigan, stated in *Issues in Science and Technology* (Winter 1985; 40-55), "AIDS is a new, transmissible, universally fatal, and thus far, uncontrollable disease." She stated further that, "From the onset it has been impossible to deal with AIDS only in the context of natural science because of the intimate admixture of issues involving sociology, psychology, politics, ethics, and the law."

In 1985, Peterman, Drotman, and Curran of CDC made the following statement: "These studies have suggested that receptive anal intercourse is a risk factor independent of the number of sexual partners. However, because the virus has been isolated from a number of different body fluids including semen, saliva, and blood, the *exchange of any of these fluids should be considered capable of transmitting the virus.*" Theoretically, one virion that gets in the conjunctiva of the eye or the mucous membranes of the nose, mouth, respiratory tract, gastrointestinal tract, or genitourinary tract could cause this fatal disease. The HTLV-III virus may also gain entrance into a non-infected body by sexual contact, from contaminated blood and blood products, through cuts or defects on the skin, or by punctures with needles or other equipment that come in contact with the blood or body fluids of an infected person.

The failure of CDC and the U.S. Public Health Service to follow up on contacts of AIDS patients, screening them with the HTLV-III antibody test and counseling them on the transmission of this fatal disease, in my opinion, will be remembered as one of the biggest mistakes in the history of medicine. Furthermore, the guidelines established by the above two organizations make routine screening of any individual or group of individuals by private physicians almost certain to result in litigation. Until routine screening of all HTLV-III positive contacts, risk groups, food handlers, premarital couples, and

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It is time for CDC, Public Health personnel and all physicians to get to basics. Our primary duty is to gather data, study it and make recommendations.

people who are involved in close physical contact, such as athletes, workers, etc., whose physical contact can cause lacerations, abrasions and toothbites with the exchange of blood and body fluids is permitted, this universally fatal disease will continue to spread. I often wonder how CDC and the Public Health Service can justify not testing contacts and hence permitting many of them to unknowingly transmit this 100% fatal disease.

In my opinion, the following should be done about AIDS:

1. Since this disease is a serious national health problem, Medicaid or some special public fund should finance the AIDS program.
2. Increase funding for research in AIDS so that a cure can be found as quickly as possible.
3. Establish centers for treatment so that all cases will get the latest and best possible treatment.
4. Educate and inform AIDS patients and the general public of the **true facts** about AIDS and what steps they can take to prevent this disease.
5. Until all factors are known, set up guidelines for all AIDS patients to prevent even accidental transmission of the disease. This should be done voluntarily by all infected persons. Guidelines should be stringent enough to prevent accidental transmission of this 100% fatal disease.
6. The following legislation should be passed immediately:
   a. Make AIDS, ARC, and all positive HTLV-III cases reportable, communicable diseases. Follow up on all contacts with screening and counseling.
   b. Premarital screening for HTLV-III antibodies.
   c. Pregnant women be screened for HTLV-III antibodies.
   d. Screening of all food handlers and health care workers for HTLV-III antibodies.
   e. Legalize pre-employment, pre-insurance and pre-college HTLV-III screening.

In my opinion, AIDS is a most serious **MEDICAL** problem. It concerns all of the people of the world, both sexes, all races, all religious groups and all minorities and majorities. It must be eliminated at all costs.

It is time for CDC, Public Health personnel and all physicians to get to basics. Our primary duties and responsibilities as physicians, health care professionals and workers are to gather data, study these data *objectively* and *scientifically,* then make recommendations as to treatment and steps *necessary to prevent* the spread of this fatal disease.

J. Nicholas Gordon, MD, is an OSMA member now practicing in Atlanta, Georgia.

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of the Ohio State Medical Journal or the Ohio State Medical Association.

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OSMA NEWS

a compilation of the latest developments, reports and products of interest to physicians.

Physician-union activity creeps into Pennsylvania

The Union of American Physicians and Dentists (UAPD), which was founded by California physician Sanford Marcus, MD, in 1972, has recently begun to gain a foothold in Pennsylvania, says an article in a recent *AMNews.*

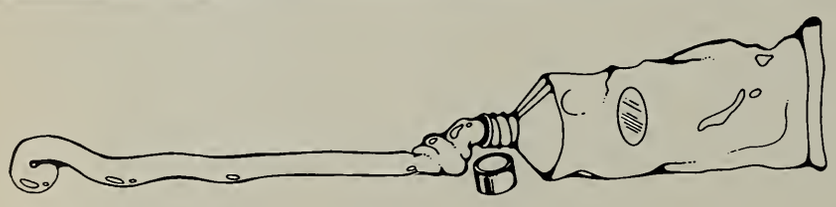
According to the report, physicians in Philadelphia and Erie began organizing union locals of UAPD in late 1985, and that, statewide, about 300 physicians are now involved in the group.

Ernestina Agresti, DO, president of the Erie local, says that other locals have been formed in Wilkes-Barre, Harrisburg and Scranton.

"I don't think the American public realizes yet what valuable quality health care is being taken away by virtue of second opinion, pre-certification, and cost-containment rather than cost-efficient efforts," says Dr. Agresti. "Coalitions all over the country are talking about cost containment for employees without even talking to the primary health providers, the physicians," she adds.

Currently, the majority of members (80 percent) are fee-for-service physicians who have contracts with HMOs and PPOs.

Whether or not these physician-members could ever legally call a strike or take other job actions is still under review, say antitrust and labor lawyers who have studied the union movement among U.S. physicians. According to these attorneys, while anyone may pay dues to an organization and call himself or herself a "union" member, only employed physicians, and usually only those who work as a "traditional" employee, are protected by labor laws from prosecution for striking or otherwise using their collective strength to force an employer to grant their demands.



Attention physician-artists!

You have until the end of this month to enter the *American Artist* Golden Anniversary National Art Competition.

A total of 75 paintings, drawings and prints will be chosen as finalists, and will be placed on tour — premiering in San Francisco, summering in St. Louis and closing in New York City. Opportunities also exist for cash and merchandise prizes — up to $20,000.

The initial judging of the competition will be done from 35 mm. slides, submitted with an entry form (or facsimile) available from the publisher of *American Artist* magazine. To obtain these forms, or for further information, contact: *American Artist* Magazine, Golden Anniversary National Art Competition, 1515 Broadway, New York, New York 10036, 212-764-7447.



Missing children: the nation's newest paranoia?

It's not that the American Academy of Pediatricians isn't concerned about the number of children who are listed as "missing" each year by parents.

They *are* concerned, of course — but they are even more worried at the prospect of this national crisis growing out of proportion. The flyers in the mail, the pictures on milk cartons, the fingerprinting at the local shopping mall are only frightening the very children over whom all this furor is being raised, they say.

According to national statistics, the overwhelming majority of missing children are *not* abducted. They run away from home. (Often, those that *have* been abducted have been taken by a parent in a divorce or custody dispute.) In fact, during 1984, out of the 350,000 children reported missing by the FBI, only 67 were kidnapped by strangers. Those are the kind of facts and figures that need to be put into perspective for parents more often, say the pediatricians.

Certainly, there is reason for caution and a need to teach children about basic safety rules, they report. But, they add, parental fear, which transfers so easily to youngsters, should be avoided at all costs.

Edited by Deborah Athy

The artful dodger

Just one of the endless billboards beside the highway. This one read: Camel filters. It's a whole new world.

The message didn't convince Dr. Michael Lippman, a family physician from Seattle, Washington. Somehow, the message didn't seem, well, complete. According to a recent article in the *Medical World News,* after the tag, "It's a whole new world," Dr. Lippman spray-painted, "of cancer."

This flourish of budding artistry landed Dr. Lippman, vice president of the state's Doctors Ought to Care organization, in the courtroom. He pleaded not guilty, planning to use a "defense of necessity"; i.e., in certain situations, breaking the law is more important than obeying it, the article stated.

The prosecution decided to drop the charge if Dr. Lippman would agree not to repeat his artistic debut. But the doctor refused. Nevertheless, the charge was dropped "without prejudice," but can be reinstated as a felony if the doctor repeats the offense.

According to Dr. Lippman, cigarette advertising is just plain "sleazy." So it's hard to tell if and when he'll strike again . . . though rumor has it that cigarette billroads in Seattle continue to be revamped.



Circumcision rate may drop

Pediatricians may soon find themselves with fewer baby boys to circumcise as more and more insurance companies re-examine whether or not to pay for the operation. Although insurance companies are willing to admit that the $50-per-infant circumcision fee is not high, it adds up when done on a large-scale basis, they say. For example, for every 100,000 infants circumcised, insurance companies must pay $5 million.

As a result, in the last few months, insurance companies in other states (including Pennsylvania) have decided to stop reimbursing for routine circumcisions, and some physicians are estimating that 35 to 50 percent of all parents are choosing to forego the operation on their infant son's behalf — a dramatic change from a 1978 study which found that 80 percent of parents chose to circumcise their sons.

Whether this change in attitude is due to the insurance company's wavering position on payment or to a recent shift in medical thought that finds routine circumcisions no longer necessary is hard to say. But physicians and insurance companies agree that the choice to circumcise is a personal decision, and one that's best left up to the parents.

Too many aspirins may aggravate headaches

Fewer aspirins may help patients off the "analgesic rebound."

The next time a patient tells you that a headache is getting worse, you might want to suggest that the patient cut down on the amount of pain medication he or she is taking.

According to a recent study conducted by the New England Center for Headaches, 82 percent of the headache sufferers being treated experienced two-thirds fewer headaches within four months of being taken off painkillers.

The findings apply to large consumption (25 tablets a week or more) of narcotics, such as codeine and aspirin substitute, as well as aspirin, says Alan M. Rapoport, MD, Director of the Clinic and assistant clinical professor of neurology at the Yale School of Medicine.

Although scientists are unsure why "analgesic rebound," as the syndrome is called, occurs only in people with chronic tension headaches (and not in people with migraines or other pains), they do know that as many as 100 million people suffer from it. Their headaches — mild, dull, and steady — occur several times a week and last from six hours to all day. Sufferers will take as many as 20 aspirin a day — 140 in a week.

Dr. Rapoport admits that it is often difficult to convince patients that they must stop taking painkillers, but they must be told that their headaches are getting worse — not better — because of the medication, he says.

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The business of medical societies — giving physicians what they want

In the "good old days," physicians joined their county medical societies largely for the educational and professional opportunities that a membership afforded, along with the camaraderie that came from meeting and talking to other physicians. Today, however, more doctors are likely to be won over by the services the society provides: car leasing, group health insurance, answering services, bill collections, travel programs, etc. And more and more, members are interested in the "dollar-for-dollar" value they are getting in exchange for their hard-earned dues.

As a result, many county medical societies have set up separate corporations to handle the business side of their operations and to help supplement revenues with non-dues income. In addition, more and more staff time is being devoted to the financial side of the operation, so that the county medical society — like the practice of medicine — is changing.

Just how to balance professional offerings with business activities was one topic discussed at the Ohio Medical Society Executives' Meeting held in Columbus on July 30. The traditional role of the county medical society is to provide programs, publications, committees, community and media relations, member services, social activities, discounts, etc., William J. Galligan, executive director of the Cincinnati Academy of Medicine, told those in attendance. "And we must maintain a structure to do that — to deliver all of these — because that is what medical societies were originally conceived to do."

Yet at the same time, Galligan continued, "we must also understand that we are in a business — that there's a structure necessary to maintain this part of the medical society as well."

More and more staff time is being devoted to the financial side, so that the county medical society — like medicine — is changing.

To date, most of the societies which have set up separate stock companies to handle their business operations are those with 500 members or more. Yet "any county society can earn $2,000 in business income per active physician," Sidney H. Mountcastle, former director of the Summit County Medical Society and now administrator of the Independent Medical Plan in Akron, said at the same meeting.



Physicians at a meeting of the Toledo Academy of Medicine.

For the society of 500 members, that $2,000 per physician — which can be made by providing members with a variety of services — adds up to one million dollars a year — money that goes a long way in supplementing dues income. But even small societies can offer options like car leasing, employment services and bill collections, Mountcastle said, offering to help anyone interested

OHIO MEDI-SCENE

The business of medical societies . . . *continued*

in exploring these opportunities.

Daniel P. MacCollum, director of program development for the Academy of Medicine of Cleveland, however, pointed out that before jumping into business, county societies need a "blueprint" that will show them whether or not these services will be feasible and profitable. "You need to ask, 'what is the condition or the economics of the idea?' " MacCollum pointed out.

He suggested making a full assessment of the situation in order to determine if members really need the service and if the society has the ability to provide it. A planning stage comes next, followed by a test market to see how well it operates and is being received.

If things go well, MacCollum continued, the service or program can be fully implemented for the membership. However, feedback must be included in the process so that the service can be periodically reassessed and altered, if necessary.

But the first prerequisite, MacCollum added, is "a strong commitment to the idea from your board." And to make it operate efficiently, "everyone on the staff must know what's going on and get involved."

In Columbus, as in other large cities throughout the state, non-dues revenues have been generated in a variety of ways, according to James S. Imboden, executive director of the Academy of Medicine of Columbus and Franklin County and president of its business arm, Physicians Service Corporation.

In addition to group health insurance, a telephone answering service, bill collections, automobile leasing, personnel placement and a travel program, the Academy offers its members automobile telephones, a special VISA card and financial planning. It is currently investigating the possibilities of providing electronic billing, practice management, micro filming and mass purchasing.

In addition, the Columbus Academy started an independent practice association (IPA) 10 years ago in order to help its members compete with the variety of alternative health care systems just beginning to emerge. Today, with HMOs spreading out all over the city, Physicians Health Plan (PHP) not only enables local physicians to compete, but it also generates a generous amount of non-dues revenue for the Academy, which still owns 51% of PHP.

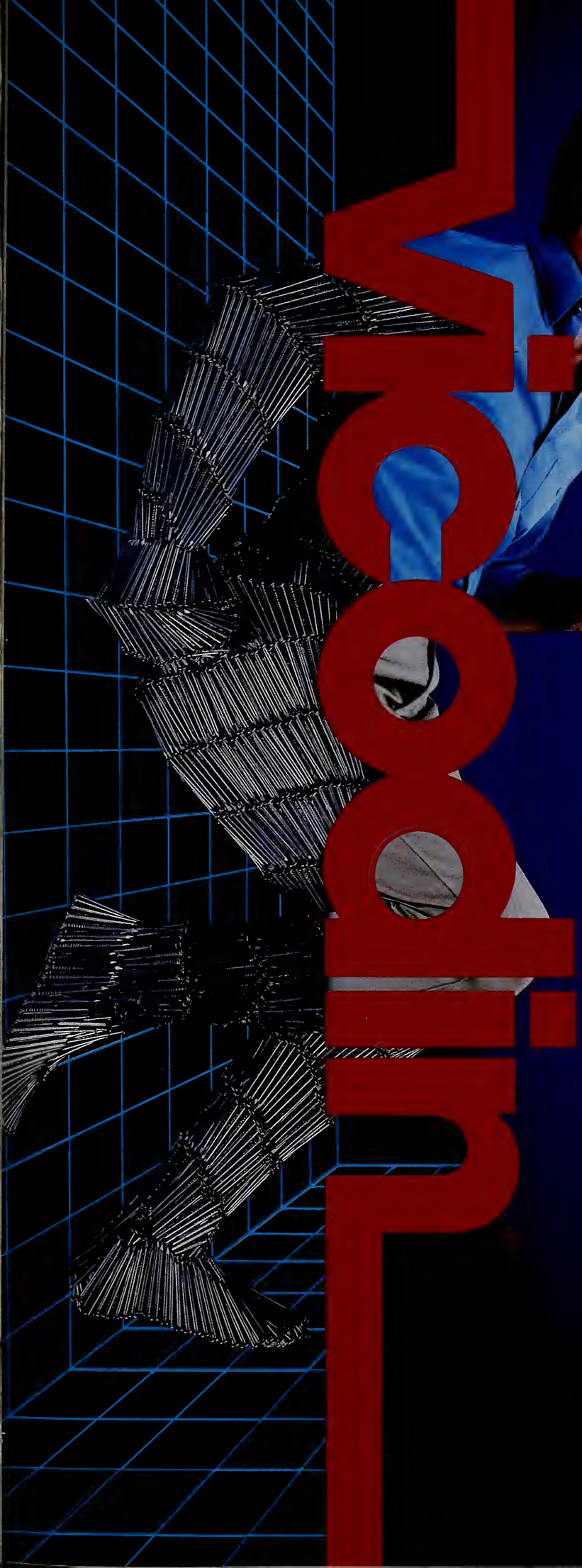
Other county societies, including Summit County, have also formed IPAs, although "Columbus in 1976 had a different environment than Toledo had two years ago and Summit County had last year," Mountcastle said. In addition, many physicians undermine the efforts of physician-owned IPAs by "signing up for every new IPA that comes down the road," Mountcastle said, adding doctors now join an average of five each.

In Cincinnati, the academy is now offering contract evaluation for its physicians, in order to help them make educated decisions on which HMOs and IPAs to join or not to join. Cincinnati is also offering a number of other business management programs and activities designed to help physicians compete and remain financially solvent, including tax planning, marketing and the use of computers in the office.

"Physicians want us to give them the tools they need to compete — and they will turn out in startling numbers for this kind of program," Galligan said. In short, county societies are having to work harder and harder to keep their members and to keep them happy, all four executives stated. Yet they struggle against a variety of odds: "the need to be all things to all people, anti-trust implications of collective activities, and competition from hospitals and other groups for allegiance," Galligan added.

In addition, it forces county medical societies into a kind of identity crisis — and one that must be resolved if physicians are going to continue looking to their county society for guidance and assistance. "It's fine to pursue extra dollars and to generate a revenue stream through non-dues

In short, county societies are having to work harder and harder to keep their members and to keep them happy . . . yet they struggle against a variety of odds.



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CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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Revised, April 1982. 5685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.



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The business of medical societies *(cont.)*

enterprises," Galligan said. "But we all have to remember what business it is that we're in and why we're in business to begin with. If we lose sight of that goal, our potential future is seriously threatened."

But that's easier said than done, Mountcastle said. "The physician's image of himself has changed so much that the traditional image of the medical society has had to change also," he said. "And if it doesn't change — the society becomes meaningless." — *Susan Porter*

Help for elderly comes from AFAR

Osteoporosis ... Alzheimer's ... glaucoma ... arthritis. No question about it — growing old has its problems.

But until recently, the degenerative, debilitating diseases of old age were always silently accepted, as if seniors had to pay something for the privilege of reaching six, seven, eight — even nine decades of life.

Fortunately, all that has begun to change. Most people can now look forward to a life expectancy of 72 years and more, and, increasingly, few who are reaching this age are willing to withdraw to a life of wheelchairs and nursing homes. They want answers about themselves and the aging process. Why, they ask, do healthy bodies change with age? Why are the aging more susceptible to debilitating disease? How can life's productive years be extended?

Difficult questions to tackle, and yet there is an organization that has decided to take these problems head-on. It's called AFAR — an acronym for American Federation for Aging Research, which was started in 1979 by Robert Butler, who was serving as the first director of the National Institute on Aging. Recognizing the need for aging research (as well as the lack of federal funding available to support it), he urged Irving S. Wright, past president of the American Heart Association, to form a private organization that would encourage and support aging research nationwide.

Two years later, Roy Donnerberg, MD, Chairman of OSMA's Committee on Geriatric Medicine, brought the concept here to Ohio by establishing AFAR's first local affiliate.

"AFAR-OA is committed to funding aging research in Ohio institutions, educating Ohioans about the need and the current state of knowledge, and voicing support for the geriatrics training that Ohio's seven medical schools now provide," says a paragraph in the group's literature about AFAR and AFAR-OA.

"We've been very lucky here in Ohio," comments Anne Castle, Development Director for AFAR-OA. "We have a Martin Janis who was able to push through the Ohio legislature a state budget appropriation which required each of the state's seven medical schools to have a geriatric department. And we have a Fifi Pfahl who, during her year as President of the Ohio State Medical Association's Auxiliary, made aging a priority issue a year before the national association did. And we have a Roy Donnerberg who brought the concept of AFAR to Ohio — so we've really been ahead of most other states as far as efforts in aging research is concerned."

"(We are) committed to funding aging research in Ohio institutions, educating Ohioans about the need, and voicing support for geriatrics training."

Ohio's lead in this area may soon be even greater if the Board of AFAR-OA is successful in launching a statewide network



Cleveland art show features medicine and the human condition

There is still time to catch "Ars Medica: Art, Medicine and the Human Condition" at the Cleveland Museum of Art.

The special exhibit — featuring more than 100 prints, drawings and photographs depicting five centuries of medical practices and attitudes toward health, illness and the value of life — will be on display in the Prints and Drawings Galleries through November 30.

The works relate to four major themes: 1.) anatomy, which was developed by both artists and physicians during the Renaissance; 2.) healers, from Christ and the saints to barber-surgeons, quacks and country doctors; 3.) disease, disability and madness; and 4.) the cycle of life, from birth and aging to the mystery of death.

The exhibition is drawn from a special collection of art related to medicine, acquired by the Philadelphia Museum of Art, primarily through grants from Smithkline Becman Corporation.

OHIO MEDI-SCENE

Help for elderly *(cont.)*

campaign which will extend both the organization's fund-raising and educational efforts.

The purpose of the network, according to Castle, is to make more people aware of the need for aging research.

"We hope to begin by linking the geriatric department of each of Ohio's medical schools with the local academy of medicine, the local medical society auxiliary and different community service groups," she says. From there, AFAR-OA is hoping the network will grow.

"It's always been difficult to get people interested in research, because it's such a long-term goal. Aging research is even worse because society has such a negative view of aging," says Castle.

However, with the number of people expected to reach old — and even older — ages in the year ahead, there is no question but that more research will be needed, she says.

With the number of people expected to reach old age, there is no question that more research will be needed.

"Our goal is to have a program which looks at the process of aging and confronts the issues and problems head-on."

Anyone wishing more information about AFAR or AFAR-OA may contact Castle at the Martin Janis Center, 600 East 11th Avenue, Columbus, Ohio 43211, 614-297-1079. — *Karen S. Edwards*



Medical research and studies in Ohio

• The Shot?

Researchers at The Ohio State University have developed a birth control vaccine which may make once-a-year birth control a reality, according to a recent article in *Discover* magazine.

But not so fast . . . The birth control shot is still being tested, and *if* it is found to be safe and reliable, chances are it won't be available in the United States until the mid-1990s, the article says.

The vaccine, which consists of the hormone human chorionic gonadotropin (hCG) attached to a protein, produces hCG antibodies which bind to fertilized egg cells

Medical research and studies in Ohio *(cont.)*

and prevent them from attaching to the uterus.

In the event that the fertilized egg does implant, the hCG antibodies prevent the release of progesterone in the ovary and menstruation follows.

Obviously, the vaccine has many advantages over its sister methods of birth control. Most importantly, a year's worth of birth control can be obtained with a single injection. In addition, researchers say the vaccine has none of the side effects associated with the Pill, such as blood clotting, weight gain and lassitude, although it's still too early to say what side effects, if any, this vaccine will have.

The World Health Organization already has begun testing the vaccine on women in Adelaide, Australia. And it may not be too long before the vaccine surfaces in countries such as China and India, where there is a shorter drug approval time and a more pressing need for birth control.

In some ways the vaccine sounds too good to be true . . . but there's always a catch. Controversy could arise regarding whether the vaccine functions as a contraceptive or an abortification, researchers say; i.e., whether the hCG antibodies affect the fertilized egg *before* or *after* it is attached to the uterus.

• Cancer and photodynamic therapy

An experimental new painless and non-invasive treatment for cancer is being tested by Jack Gluckman, MD, the director of head and neck surgery at the University of Cincinnati.

The technique under study is photodynamic therapy, which relies on a light sensitive chemical being injected into the body. This chemical — a hematophyrin derivative — is retained mainly in cancer cells. When it is exposed to light, such as an argon laser, the chemical is activated, causing the cells to die. Shortly after exposure to the laser light, the tumor begins to dry up, then crumbles and falls away over the next few days.

Because the chemical also fluoresces red when exposed to certain kinds of light, it can signal to physicians the presence of cancers only a few cells large when coupled with an image intensifier.

The University of Cincinnati Medical Center is presently coordinating research in photodynamic therapy among eight medical centers throughout the country. The goal is to apply the treatment on 100 head and neck cancer patients. Results will then be compared to results of 100 similar cases treated with surgery.

The obvious advantage photodynamic therapy has over surgery is its non-invasive nature. There is no disfigurement, as is often associated with surgery; healthy tissues do not have to be removed, and it can be done with a local anesthetic.

The chemical itself appears to be safe and non-toxic to humans. Its only drawback is its sensitivity to the sun (patients must stay out of the sun for up to four weeks after treatment) and its variable absorption rate. Dr. Gluckman says that in order for the technique to be successful, it is important that the absorption of the chemical and the penetration of the light be precisely controlled. Otherwise, cancers may be undertreated and allowed to spread.

• The pulse oximeter in adults with respiratory problems

Research is being conducted at Akron General Medical Center by doctors Darell Heiselman, Lou Cannon, Jeffrey Jones and Richard Gradisek to evaluate the reliability and clinical usefulness of the pulse oximeter in adults with respiratory problems. It is hoped that this method will prove superior to the conventional analysis of arterial blood gas samples which has many drawbacks, such as invasiveness and risk of error due to sampling technique, sample transport and analysis. Furthermore, because the blood gas values may change rapidly, intermittent sampling may not reflect the current status of the patient. Use of the pulse oximeter is a non-invasive procedure that will give a reading in a short period of time and not cause the patient any discomfort.

• Flexible lens for cataract surgery

John Marquardt, MD, of Mansfield, is one of several ophthalmologists who is evaluating a new soft, foldable intraocular lens which will be used to replace the natural lens which has been clouded by cataract and removed during surgery. The lens is made from a type of silicone which may be folded to fit through a three millimeter incision — half the size of that required by standard hard implant lenses. The soft material and smaller incision mean faster physical rehabilitation and a faster return to corrected vision. The lens was designed by Thomas R. Mazzocco, MD, a California ophthalmologist.

The lens is made from a type of silicone which may be folded to fit through a 3mm incision.

• Studies in AIDS (Acquired Immunodeficiency Syndrome)

Doctors Evelyn Hess, Alan Solinger and Louis Adams, of Cincinnati, have been conducting a number of studies on the HTLV-III virus, how it started and its effect on the body. For example, their studies include a look at: 1) The incidence of autoimmune reactions, antibodies and disease in AIDS patients shows a striking absence of these phenomena in the over 400 sera and patients studied to the present time. This is of major interest as patients with AIDS have evidence of polyclonal B-cell activation with marked hyperglobulinemia, the presence of antibodies to many viral, parasitic and protozoal antigens as well as the well-known cellular immune abnormalities.

2) Another study collaboration with the New York University School of Medicine has identified that about 30% of AIDS patients have antibodies to sperm and to seminal plasma using, respectively, indirect immunofluorescence and

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OHIO MEDI-SCENE

Medical research *(cont.)*

hemagglutination assays. The antibodies to sperm show that the majority of the reactions are to the acrosome, followed by the tail, then postnuclear and equatorial regions of the sperm. Seminal plasma has been found over many studies to have an immunomodulatory role and may provide one of the risk factors for AIDS.

3) Other studies in AIDS concern the types of cells found in bronchoalveolar lavage. An interesting finding was the presence of dual labeled lymphocytes (T-4 positive and T-8 positive), thus indicating an immature immune system.

— Compiled by Karen S. Edwards

Past achievements, future goals

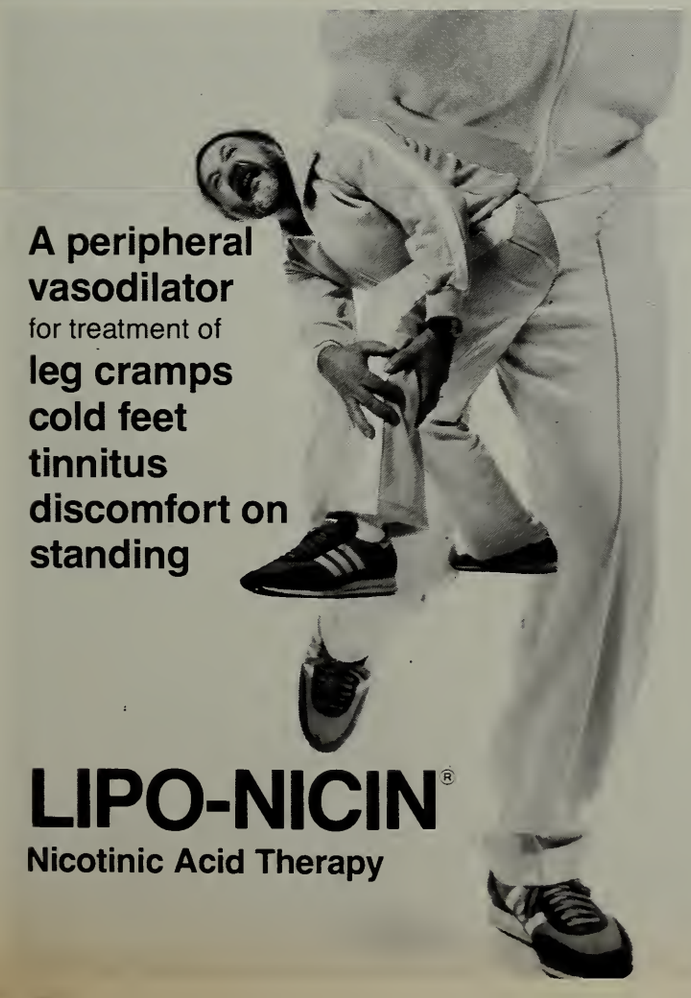
Speaking recently at an Ohio Department of Health awards banquet, Governor Richard F. Celeste called for renewed efforts to close the health gap between white and black Ohioans.

"Too many black infants never see their first birthday, too many black women die in childbirth," he pointed out.

The Centennial Awards were presented to 10 Ohioans who have made significant contributions to public health care, especially in preventive medicine and children's medicine.

Some of the recipients include: Dr. Henry Heimlich, chairman of the Department of Advanced Clinical Science at Xavier University in Cincinnati, for development of the "Heimlich maneuver"; Dr. David L. Jackson, former director of the Ohio Department of Health, for developing the Ohio Solid Organ Transplant Consortium; and Helen Berry, director of the Metabolic Disease Center at Cincinnati's Children's Hospital, for research in metabolic screening of newborns.

> ***"Too many black infants never see their first birthday, too many black women die in childbirth."***



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Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide.....75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) .....25 mg.
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Marketing and Advertising

A Curse or a Cure for Hospital Woes?

By Susan Porter

It all started about 10 years ago with what are known in the advertising industry as "warm and fuzzies." Falling somewhere between a community service announcement and a greeting card commercial, these soft-spoken, unobtrusive hospital ads delivered messages like "We care," "We're at your service," and "Here's to your good health."

Their purpose was largely to raise the public's level of awareness of the hospital and to improve its overall image, says Linda P. Trafford, director of health care marketing for Gerbig, Snell/Weisheimer & Associates, Inc., one of the first agencies to develop TV hospital ads in the state.

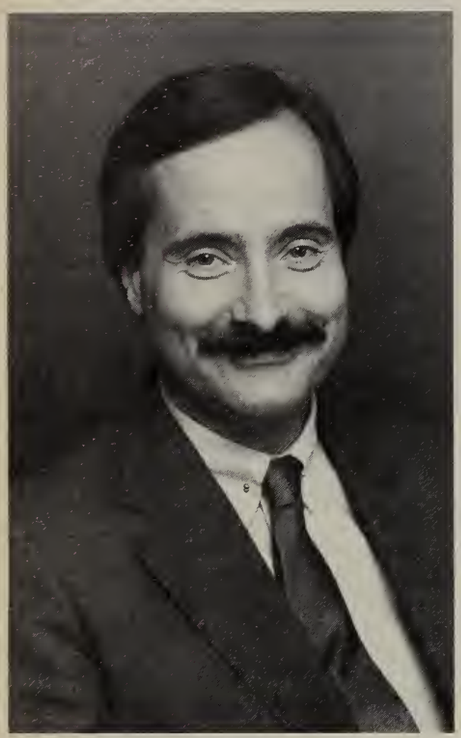
They were also the subtle beginnings of what has become a literal tidal wave of hospital marketing and advertising efforts designed to sweep patients off their feet and into the emergency rooms, maternity wards, cardiac care units, alcohol rehabilitation programs, sports medicine clinics and women's centers of hospitals across the state, leaving physicians — the traditional gatekeepers to most hospital services — in the wake of the flood.

Today, in many instances, the messages hospital advertisements deliver are no longer soft and subtle. Rather, they are graphic, specific and to the point in the health care "products" and services they are offering. Their TV, radio and newspaper ads depict patients delivering babies in "birthing centers," surgeons discussing coronary care procedures, and emergency room personnel explaining their newest technologies and equipment.

Still their bottom line message in this highly competitive and sometimes controversial effort is "Come to us," Trafford says, estimating hospitals in Ohio spent around $40 million to that end last year, with some marketing and advertising budgets now in the seven-figure range.

What's more, hospital advertising and marketing efforts have gone beyond the scope of TV, radio, newspaper, billboard and direct mail advertisements. Many hospitals are even going outside the health care arena to attract new business — starting food service and catering businesses, hotels, restaurants, transportation services and Caribbean cruises for patients. (See related story.) One hospital in Tennessee, says Trafford, is even offering carry-out pizzas.

So what has happened in health care to make hospitals take such steps — to venture out into the marketplace and to use so-called "hard sell" advertising techniques



John Gillespie, Jr.
Cleveland Metropolitan General Hospital

"What we have here in Ohio is a dwindling demand for inpatient care and an excess supply of hospital beds."

to bring more patients to their doors? More importantly, what does all of this mean to physicians, many of whom are also struggling to stay alive in this new, highly competitive health care "industry," and just how far will all of this go in the future?

"These changes in attitude are fundamentally tied directly to changes in the reimbursement system," says John Gillespie, Jr., vice president of marketing and external affairs for Cleveland Metropolitan General Hospital. "The DRG system, which allows only a certain amount of money to be paid for certain types of care, encourages more outpatient treatment, and so a lot of entrepreneurs have started outpatient clinics which compete with traditional hospital services," Gillespie says.

DRGs and other efforts to contain health care costs also have led to a smaller number of inpatient days, Gillespie continues, forcing many hospitals to take a hard look at their empty beds, lost revenues and unused equipment and staff. "What we have here in Ohio is a dwindling demand for inpatient care and an excess supply of hospital beds," Gillespie says.

And, as in any enterprise, an oversupply of services means increased competition for those patients still requiring inpatient care, along with a shift from what traditionally has been a seller's market — with hospitals and doctors setting the rules — to a buyer's market. Today, patients, insurance companies, government and other third-party payors are calling many of the shots, says Gillespie.

"Hospitals today are more financially at risk than they've ever been before," Norm Spuehler, vice president for communications and administration for the Ohio Hospitals Association, explains hospitals' new emphasis on marketing. "More than 50% of hospital inpatient admissions are now paid for by government on a prospective basis."

Thus hospitals are constantly struggling to find new ways to reduce their costs and at the same time to attract a greater share of the market. Also decreasing the number of inpatient days, Spuehler points out, are more preadmission and stringent peer review procedures, along with other cost-cutting measures implemented by third-party payors.

"As third parties were granted more and more control over payment mechanisms — becoming more diligent in what they would or would not pay for — hospitals were forced to promote themselves and their services," says Rebecca J. Doll, vice president of Market Group One, a health care marketing agency based in Columbus. Thus hospitals felt the need to go not only to potential patients to attract new business, but also to employers, insurance companies, PPOs and other alternative deliverers in attempts to keep the business they already have, Doll says.

And their marketing efforts go well beyond advertising, Doll adds, explaining advertising is just a small part of a well-rounded marketing effort, which must also include planning, research and both internal and external audits of the particular situation. Other parts of the package include not only courting third-party payors to allow patients to be treated within the hospital system, but also developing better physician relations, since physicians to a large degree still determine where patients go for hospital care.

In order to attract physicians and foster a sense of loyalty, "hospitals have always offered incentives like office space, parking and equipment," Doll says. "But today, they're becoming

much more aggressive." Some hospitals are going into joint ventures with physicians in freestanding clinics and surgicenters, many are sponsoring workshops and seminars on how physicians can better market their own practices, and most now promote their medical staffs through physician referral services.

All of this is designed not only to keep physicians happy, says Doll, but also to keep referrals coming in, to fill up hospital beds and to keep equipment and staff members busy. And not all of the negotiating is friendly.

Some hospitals are taking a tough stance on giving physicians admitting privileges, says Doll, and are forcing doctors to sign exclusive contracts with them in order to use their facilities. "What they're saying is that we will let you be on our staff, but you must sign a non-competing agreement not to practice anywhere else. You will send your patients here and only here."

And in a few instances, says Doll, hospitals are going to existing physician-run clinics, offering partnerships and threatening to open up new clinics if physicians don't agree to join them. Thus one of the services Market Group One offers, says Doll, is helping physicians to negotiate the best possible contracts for themselves under the circumstances.

But perhaps nothing is quite so fierce as the competition that now exists between the hospitals themselves, and this is where the crux of the advertising and marketing effort lies. "That club of hospitals which once existed with everyone supporting everyone else is now gone," Gillespie says.

Out of economic necessity, each hospital has been forced to look out for its own best interest because "hospitals today *can* go out of business," says Grant Carter, vice president of marketing and human resources at Clinton Memorial Hospital in Clinton County. Therefore, "They have to operate in a more businesslike manner and become more sensitive to traditional marketing techniques."

And it's no longer one big city hospital competing against another. Rather, it's the small rural hospital trying to keep its patients from being lured away to the nearby metropolitan hospital; the county hospital fighting for its share of full-paying patients; the community hospital trying to stay out from under the shadow of the for-profit chain. For most hospitals today, advertising and marketing are not the frivolous, high-cost activities that some observers perceive them to be. Rather, they are survival techniques that many hospital administrators are using as reluctantly as physicians.

Gillespie, Cleveland Metropolitan General's first "marketeer," says much of his first year with the hospital was spent educating hospital staff and administrators about the need for and importance of marketing — the hospital has yet to run a paid advertisement.

"We have a very unique situation here," says Gillespie, "in that we're the county hospital, and so a lot of people picture us in a 1910 building with Naugahyde chairs and frame beds. In fact, we're a very modern hospital with exemplary facilities and a high quality staff."

In addition, the hospital competes with, among others, the prestigious Cleveland Clinic and the University Hospitals of Cleveland for patients. No longer, says Gillespie, could Cleveland Metro afford to sit back and wait for patients to come and "discover" its merits. However, it did not charge ahead with a full-fledged advertising campaign.

"You don't go out and start



Rebecca Doll
Market Group One

"As third parties were granted more and more control over payment mechanisms — hospitals were forced to promote themselves and their services."



Grant Carter
Clinton Memorial Hospital

"When a hospital spends millions of dollars developing and promoting a program, it better be meeting the true needs of the people."

advertising just because the hospital down the street is advertising," he says. "First you have to know your own strengths and weaknesses. Marketing is built on detailed research. You have to know where you are getting business and where you are missing opportunities. For example, if every other hospital in the city is offering a particular service, the market is probably already saturated — so that's not necessarily where you want to go."

Once strengths and needs have been determined, goals can be set for "positioning" the hospital in the marketplace. Increasingly, says Gillespie, hospitals are dividing up the market by establishing "centers of excellence" — specializing in areas such as open heart surgery, orthopedics, emergency care or neonatal care — and then building reputations in these areas which they hope will carry on to the other services the hospital offers.

At Cleveland Metro, promoting the hospital's regional burn center and helicopter emergency service has helped to eliminate its erroneous turn-of-the-century image. Rather than buying paid media advertising, the hospital promotes its program through brochures and other direct mailings, including a sophisticated quarterly magazine it now publishes for patients.

Carter, the former director of marketing for one of three community hospitals in Miami County, says there was little need to convince that hospital and its staff that marketing and promotional efforts were needed. With three hospitals serving only 95,000 residents, the competition for patients was fierce, says Carter, before the three hospitals finally decided to join forces and merge in order to better serve the people of the area and to prevent a for-profit chain from taking over one of the hospitals.

"More and more, the smaller hospitals are being managed or purchased by the for-profits," says Carter, and those who wish to remain independent must come up with unique ways to stay viable. Some do so by signing affiliation agreements with larger hospitals who will promote and market the rural acute care facility in order to receive referrals for tertiary care. Others join in cooperative agreements with neighboring hospitals to hold their territory, and some simply close their doors, leaving a geographic gap in health care delivery.

Clinton Memorial is the only hospital in rural Clinton County, says Carter, and the competition there is much less visible, but still exists. There, some patients travel to Dayton, Cincinnati or Columbus hospitals for care, "because there are some who feel that you have to go to a big urban hospital in order to get good care." A good marketing program should convince them otherwise, he says.

The hospital is now in the process of identifying more specifically the perceptions the community has of the hospital, along with the needs of patients there. "After that, we will develop an action plan and implement that plan over the next several years, he says. The proper research is critical, says Carter, because "when a hospital spends millions of dollars developing and promoting a program, it better be meeting the true needs of the people."

Even rural hospitals are carving out their own little niches in the marketplace in this way, hoping to assure themselves at least a slice of the shrinking health care pie. For example, Brown County General Hospital, 45 miles from Cincinnati, has taken advantage of its remote location by opening a drug and alcohol rehabilitation

center.

According to Dave Ferrell, administrator, the hospital offers a "retreat-like atmosphere" along with anonymity for high-level executive patients who may not want to be seen getting this kind of treatment in a large city hospital. In addition, "We're offering cocaine treatment, because no one else in the Cincinnati area seems to be doing that specific problem real justice," says Ferrell.

Among other services hospitals are promoting as drawing cards are maternity, emergency room, women's services, plastic and reconstructive surgery, impotence treatment, sleep disorders and sports medicine clinics, because these are consumer-driven areas, says Trafford. "Patients can choose directly to use these services, as opposed to being referred to them by a physician." For this reason, these are also the most featured in media advertising.

However, in order to build overall usage of all hospital services, the physicians are still the key market, says Trafford, predicting a heavier emphasis on improving physician relationships in the future.

"The entry point to the health care system is still the physician," says Trafford. "When it comes down to it, a patient isn't going to change his or her doctor just to get into a particular hospital. Advertising can influence, but it isn't the final word."

In addition, the pay-backs advertising brings are difficult to measure because patients don't automatically flock to a hospital for cardiac care, just because they heard an ad on TV. Even harder to determine is the influence image-building ads have on patients. "You might say a particular ad campaign was successful because it increased the consumer's awareness of the hospital or it helped to give it a better image," says Trafford, "but the bottom line is how did it affect occupancy rates?"

Sometimes advertising can even be counterproductive, alienating and angering patients, not to mention physicians.

With patients, says Doll, there can be a "consumer backlash. It's like with the utility companies. People want to know why you're spending all of that money on advertising when you should be trying to lower your costs."

Physicians have been even more vocal in their opposition to hospital advertising. In Toledo, the Academy of Medicine received so many complaints from physician members regarding hospital advertising that it decided to conduct a survey, says Lee Wealton, executive director of The Academy of Medicine of Toledo and Lucas County. "We even received a letter from an entire medical staff complaining about the situation here," Wealton says.

Therefore, the academy recently mailed out the following three statements and asked physicians to check the one with which they most strongly agreed:

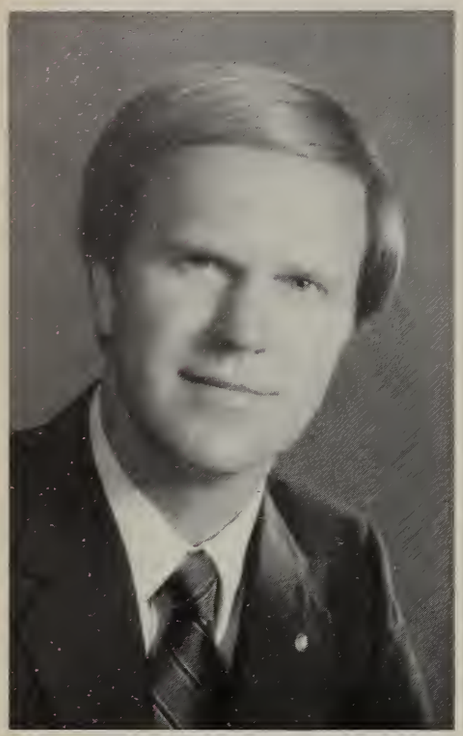
1. "I am opposed to hospital advertising because it increases unnecessarily the cost of medical care and feel the Academy of Medicine should unequivocally be opposed to its continuation."
2. "I realize that the hospitals will continue with their marketing efforts, but believe the best policy is a vigorous effort to monitor such advertising for ethical and factual content, as is presently done."
3. "I feel the Academy and individual physicians should take no stand on dealing with hospital advertising."

Out of 855 questionnaires, a surprising 404 were returned. A full 215 of the respondents, or 53%, checked answer number one, and another 180, or 45%, checked number two. Only nine physicians



Linda P. Trafford
Gerbig, Snell/Weisheimer & Associates

"The entry point to the health care system is still the physician. Advertising can influence, but it isn't the final word."



Lee Wealton
Academy of Medicine of Toledo and Lucas County

The Toledo Academy received numerous physician complaints about hospital advertising: "We even received a letter from an entire medical staff complaining about the situation here."

said the academy should not be involved.

The academy's council recently voted to send the results to all hospital CEOs, chiefs of staff, and PR and marketing directors in the area, and the survey will be published in a future issue of the Toledo Academy's bulletin.

Trafford believes a major component in the opposition is that "physicians have been trained primarily to view their progression as one not needing to be promoted in this sense. Health care issues are life and death issues and as such they need to be treated very seriously."

Still, handled professionally and properly, hospitals and even physicians can use marketing and advertising techniques to the benefit of themselves and their patients, she adds. For example, hospital marketing and advertising go a long way in letting the public know about new technologies and the types of health care services available in their communities. They also make patients more aware of their own health care problems and the need to seek help under certain conditions.

"Physicians have a lot to gain if they create alliances with their own hospital marketing people," she says. "However, all efforts must be tasteful and ethical" — and that's not always easy.

General guidelines include making sure all statements are valid and true and avoiding testimonials, guarantees or claims that can't be substantiated. The latter includes statements like "the best," "the only," "the first," and "the finest," because "quality can't easily be measured," says Trafford. In addition, "You can't guarantee a cure or promise a result that may not happen."

Physicians across the state also have expressed opposition to those ads featuring experimental drugs and treatments as state-of-the-art medicine, or to any ads which mislead patients or require them to make difficult medical judgments.

Ernest G. Brookfield, MD, the current president of the Toledo Academy, reported in The Bulletin's September "President's Corner": "Some physicians pointed out the marketing claims are inaccurate; others noted that claims for exclusivity of medical services are invalid in our sophisticated medical community. Physicians also are concerned that marketing of special services and facilities has attempted to remove patients from medical services now included in their private practice."

Still, he notes, "Marketing is an accomplished fact and is here to stay." And physicians — as well as hospitals — have a responsibility to see that it is carried out ethically and professionally.

"If we as physicians feel that a particular area of marketing is inaccurate, misleading or offensive to our professional standards, then it is our responsibility to vigorously express these feelings to our colleagues on the executive committees as well as the hospital staff," says Brookfield. "Hospitals must maintain their relationship with physicians as well as the public, and are aware of our concerns. With reasonable vigilance and active interest, we as physicians should be able to live with a marketing atmosphere that does not discredit the high standards of the medical profession."

Hospitals realize they need to keep physicians as well as patients happy if they want to stay viable, says Doll. Thus she and others are predicting a shift away from the hard-sell media advertising and the placement of more emphasis on physician relations and patient relations. The latter includes a number of low-key techniques that can be just as effective in the doctor's office as in the large city

hospital: urging staff to be friendly and courteous, giving patients information about their health care problems, streamlining billing procedures, and making follow-up calls about patients' progress.

Trafford agrees, saying more and more hospitals are getting in so-called "guest relations" and are actually consulting with hotels on how to better handle their overnight customers. Fancier furnishings, candlelight dinners and even take-home soaps are being used to help patients remember their hospital stay as a more pleasant one.

She also predicts that hospitals in the future will be advertising prices and may even offer coupons and package deals for certain services — which is likely to create another flair of criticisms. "Again this has to be done with good taste," she says, "but from the patient's point of view, this could be a valuable public service."

In essence, marketing is a mind-set, says Carter. "It's being customer or patient-oriented. And that's the way it always should have been."

Susan Porter is Associate Editor of **The Ohio State Medical Journal.**

"If we, as physicians, feel that a particular area of marketing is inaccurate, then it is our responsibility to vigorously express these feelings."

Ernest G. Brookfield, MD
President, Academy of Medicine of Toledo and Lucas County

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What's New in Hospital Marketing?

By Deborah Athy

While hospital marketing in Ohio has not reached the proportions that it has in, say, Las Vegas — where in one hospital, a woman reportedly makes her rounds dressed as a Playboy bunny — it is still in full bloom.

Hospitals are spreading the news in newspapers, magazines, television, radio, not to mention hospital-produced publications, about their full gamut of services, including drug and alcohol treatment, cancer and impotency clinics, same-day surgery, medical motels, and specially tailored maternity centers.

Everyone is entering the marketing enterprise. And those who hesitate fear they may be lost. As one hospital administrator recently explained it: "It's (advertising) one of those things — certainly it's reactive — but I don't think there's a hospital in Columbus that can afford not to advertise. You'd just get knocked out of the market."

Apparently, this philosophy rings true for other Ohio cities besides Columbus. For now, the marketing trend only promises to get bigger.

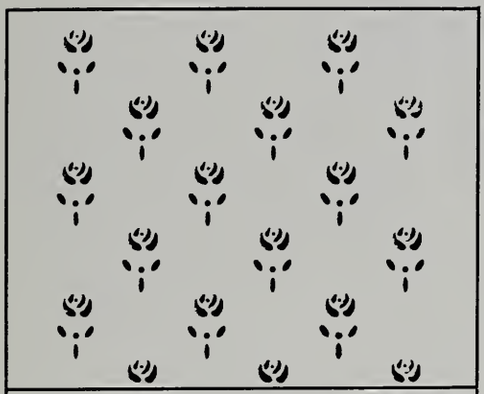
What are some of these Ohio hospitals doing to attract patients? Read on.

Salmon mousse??? The typical hospital's bill of fare has never been regarded as gourmet, but Doctors' Hospital North in Columbus has something up its sleeve to change that critical opinion. Licensed by the state of Ohio as a catering service, the hospital's dietary department boasts a diverse and sometimes exotic menu ranging from fruit, cheese and pastry arrangements to liver pate, escargot and salmon mousse. Catering at dinner and cocktail parties and other social shindigs, the service handles approximately 10 to 20 engagements per week.





On the road . . . Health Bound™, Toledo Hospital's medicine-on-wheels innovation, is designed to bring health screenings and wellness programs to the workplace. This vehicle is equipped with two examination rooms, a soundproof booth for hearing tests, and areas for blood pressure, vision and laboratory testing. A series of wellness programs, including smoking cessation, back care and safety, diet and weight control, breast cancer awareness, stress management, and fitness and exercise are promoted. Physicals and health fitness appraisals are also available. Along for the ride are physicians, nurses, respiratory therapists and other health care professionals.

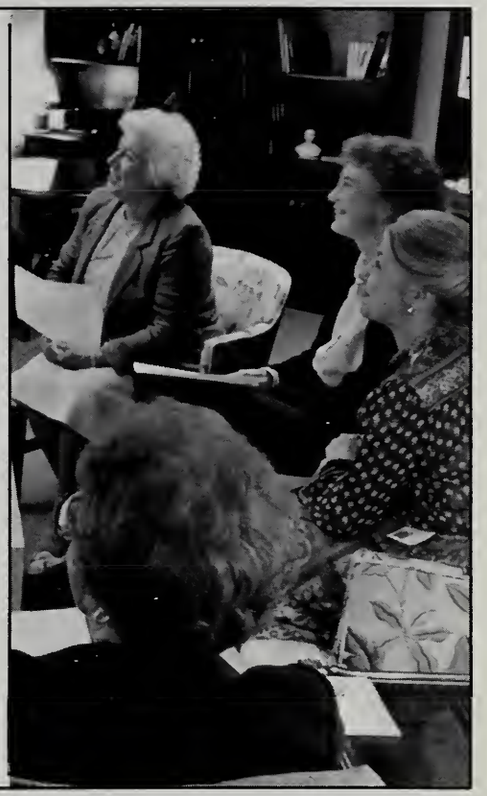


New Life Center . . . The brochure describing the center is pale pink and decorated with miniature roses, faintly resembling baby-room wallpaper. Inside the pamphlet, the delicate flower motif is continued, along with a description of the "family-centered maternity care philosophy" which is nurtured at Akron General Medical Center's New Life Center. For mothers and fathers-to-be, there are classes in childbirth preparation, breast-feeding, parenting and infant care, and post-delivery diet and exercise, to name a few. There are also pre-baby tours of the nursery and the birthing and delivery rooms. As a little aesthetic touch, the maternity rooms have been newly decorated.

Golden opportunity . . . As part of the Senior Courtesy Program in operation at Mercy Hospital in Columbus, senior citizens are privy to an unusual discount. The way it works is that the elderly will only be required to pay for what their Medicare or supplemental insurance will cover. Hospital spokespeople say they hope the discount will increase admissions and, therefore, even out the losses.

Hitching a ride . . . Deaconess Hospital of Cincinnati offers a transportation service designed to ferry patients to and from the hospital for $3 a ride. While primarily part of the specialized gerontology program there, the service is not limited to the elderly. The service, open Monday through Friday 7:00 a.m. to 7:30 p.m., covers a six zip code area.

Classes and counseling . . . Many hospitals are opening their classroom doors, offering almost every kind of health-related and pro-wellness subject in existence. Some hospitals are taking it one step further. Fairview General Hospital in Cleveland, for example, features a "Starting Your Own Business" class, and Cleveland's St. John and West Shore Hospital is also into "Taking Care of Business." At Good Samaritan Hospital in Dayton, the calendar is jammed with happenings, with classes on coping with bereavement, eating disorders, cancer and impotency. Likewise, the Elizabeth Blackwell Center at Riverside Methodist Hospital in Columbus offers classes on retirement, impotency, smoking cessation and breast education, among others.

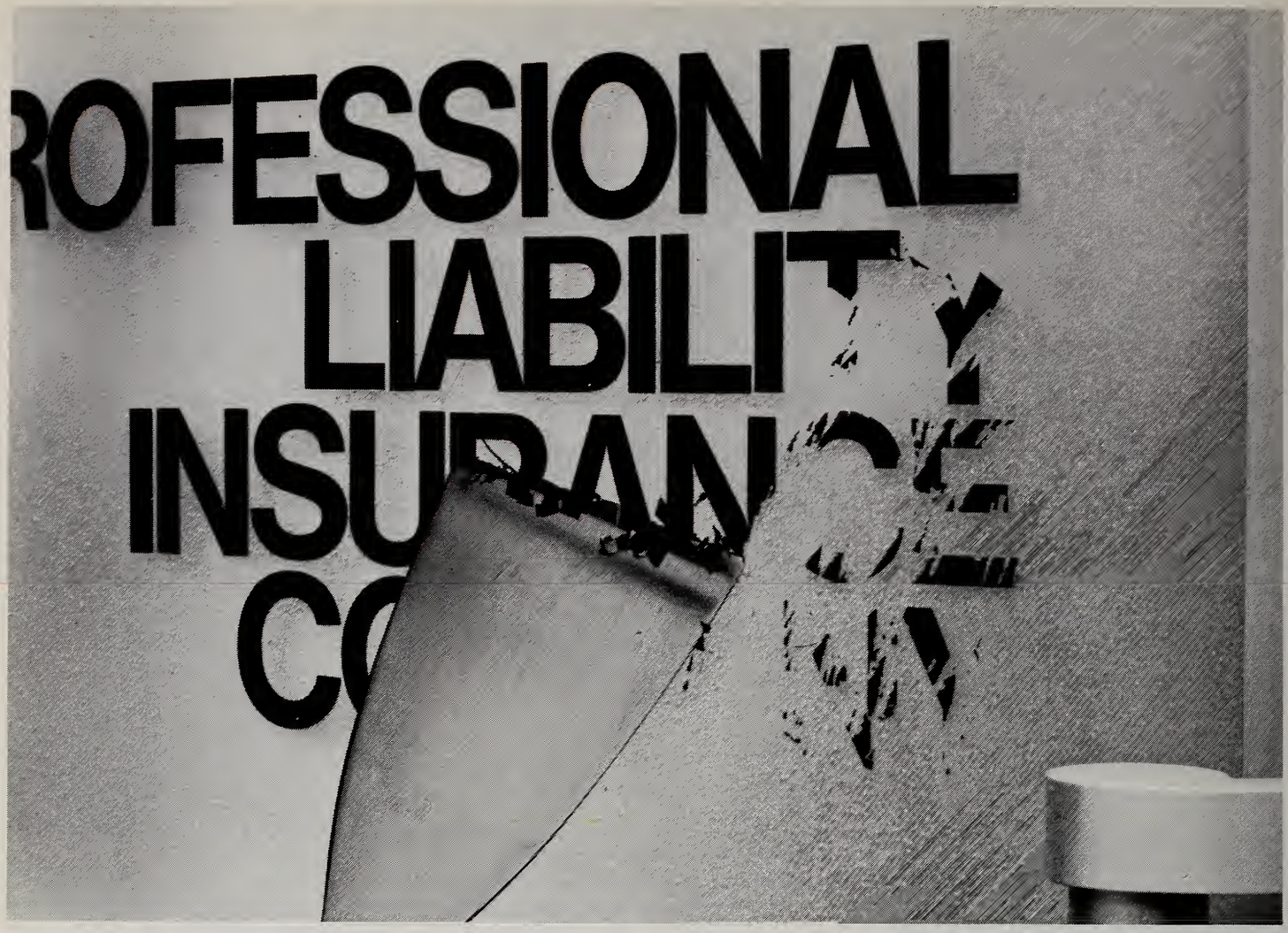


All aboard . . . Planning a trip to Egypt — land of the Sphinx, the great pyramids? Or maybe an African safari is more up your alley — plains interrupted by giraffes, rhinos and clusters of pink flamingos. If so, the Akron General Medical Center wants to be on your immediate itinerary. The Immunization Clinic for International Travelers offers jet-setter services including cholera, typhoid and yellow fever vaccination, typhus and diphtheria/tetanus immunization, and malaria and diarrhea prevention. In addition, the service provides the names and addresses of physicians in the countries you plan to visit.



Caribbean excursion . . . Speaking of trips, the Pulmonary Treatment Center at University Hospitals of Cleveland recently organized a seven-day Caribbean cruise for 20 pulmonary patients. A pulmonary physician and other hospital personnel accompanied the patients, and adequate supplies of oxygen, medication, wheelchairs and specialized equipment were included in the luggage. While the patients covered the cost of the boat ride, the medical services and supervision were on the house.





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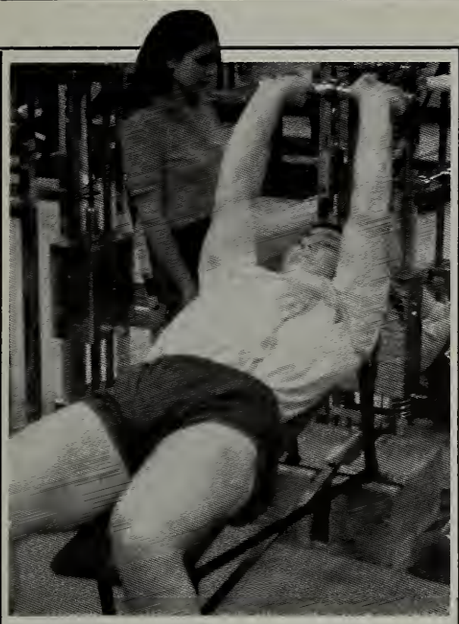
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The swing of things . . . Just watching Ivan Lendl smash tennis balls at the U.S. Open is enough to make almost anyone hanker to get back into the swing of things. The Grant Medical Center Fitness Center (Columbus) could be a means to that end, with nautilus and free weight equipment, aerobic classes, a jogging track, whirlpool, sauna and steam room. The facility stresses "total fitness," and is available not only to patients for therapeutic and rehabilitative purposes, but also to the community at large. Exercise plans are medically supervised and individually designed, with emphasis on diet, exercise, lifestyle and specific health risks.

One Stop Pre-Op . . . Mansfield General Hospital's outpatient surgery service sounds like a slogan for a convenience store. That's because the service is designed to make the surgery experience less hectic and more convenient and efficient for the patient. The One Stop Pre-Op program takes place every Wednesday at 7:00 p.m. At this time, patients scheduled for surgery in the near future can register, have physician-ordered tests taken care of — such as x-rays, EKGs and blood tests — attend a question and answer period, and see slide presentations of outpatient surgery. That way, on the morning of the scheduled surgery, the patients are several steps ahead of the game.

Hotel Oasis . . . It is not the typical run-of-the-mill hotel, but it functions in a hotel capacity for those individuals who require some type of limited care, such as homebound invalids, outpatients who require ongoing care, and discharged patients not quite ready to go it alone. Located at the Harrison Community Hospital in Cadiz, the respite care program offers rehabilitative care, physical therapy and laboratory work. Along similar lines, Deaconess Hospital in Cincinnati also provides an oasis for overnight guests, surgery patients and their families by offering guest rooms — replete with TV, telephone and rollaway (and no restrictions on children).



Kid gloves . . . The ad for the Women's Health Center of Lima Memorial Hospital in Bellefontaine says: "You'll feel like a woman, not a patient." The center offers mammography and osteoporosis screenings and information in a unique setting which includes: flowered wall coverings; furnishings; mirrored dressing rooms; background music; refreshments; robes instead of hospital gowns; and complimentary health and beauty kits.

Great American pastime . . . If you're enjoying one of America's favorite pastimes, i.e., shopping, at the Salem Mall in Dayton, you may run across a little shop which is promoting more than just a rack of trendy jeans. Family Works$_{SM}$, Good Samaritan Hospital and Health Center's "family center," is thus far thought to be a one-of-a-kind innovation in the U.S. Open seven days a week, Family Works$_{SM}$ provides child enrichment programs, information on health care resources and doctor referrals, a reference library, and collection of video tapes. What's more, in the midst of a busy mall, the center is a welcome haven for mothers or fathers who need to feed or change infants.



House calls . . . While not the proverbial type of house call, Akron General Medical Center and St. Elizabeth's in Dayton are now offering a series of medical programs which can be conducted by appointment at your home or at any club, organization or group meeting. Some of the features of the Akron program include: Heart Health, Cancer Concerns, and Nutrition and Dietetics, which highlights "Yesterday: Butter and Eggs; Today: Kiwi and Carrots." The programs are free-of-charge and are led by physicians, nurses, and other medical personnel.

Deborah Athy is the Assistant Editor of the **Ohio State Medical Journal.**

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CANCER MORTALITY RATES AND TRENDS FOR WHITES AND NON-WHITES IN OHIO: 1956-1983

K.K. Namboodiri, PhD

Recognizing the steadily increasing trends in cancer mortality, the National Cancer Institute has urged state and other agencies to target for a 50 percent reduction in rates from the current levels by the year 2000. In this context, some insights into the cancer burden of Ohio are needed to provide a framework for designing and targeting cancer control efforts in the state. Since no statewide cancer surveillance data are available for Ohio at this time, the only reliable indicator of the cancer burden is the mortality data. Therefore, in this paper, the temporal dynamics of cancer mortality for Ohio for nearly three decades are delineated with special emphasis on mortality differentials by race, sex, anatomical site, and geographic subunits. The overall cancer mortality in Ohio is significantly higher than the national rate, suggesting the need for aggressive cancer control efforts in the state.

Cancer has recently emerged as a major public health concern, not only because it is the second leading cause of death and the only one among the major causes that is steadily increasing, but also because of the associated protracted human suffering and economic impact. In recognition of the seriousness of the problem, the National Cancer Institute has formulated a set of objectives and actions to bring about a 50% reduction of adjusted cancer mortality rates by the year 2000, from the projections for that year based on current trends.[1] In translating the national objectives to the state level, the wide geographic variation of the cancer mortality and morbidity should be taken into account. Thus a better understanding of the cancer burden specific for Ohio is highly desirable to design cancer control programs reflecting the particular needs of the region.

According to the American Cancer Society figures, Ohio ranks about tenth in the nation with respect to cancer mortality.[2] The morality rate of 212 deaths per 100,000 is much higher than the national rate of 194 per 100,000.[2] Although estimates of new cancer cases and deaths for Ohio for 1985 by major anatomical sites are available as shown in Table 1, these are mainly based on available national statistics.[3] In order to gauge the size and scope of the cancer problem in Ohio, a statewide voluntary cancer incidence reporting system is currently being implemented. Until such time as the cancer incidence and survival data become routinely available, we have to rely on mortality data to gain insights into the trends and determinants of the cancer problem.

Although catalogues of cancer mortality rates by country for the United States[4-6] and for the whole or parts of Ohio in varying degress of detail[7-8] have been reported, these are confined to broad time frames and/or specific racial or geographic groups and hence are of limited scope in eliciting reliable temporal trends. The present paper, therefore, is aimed at augmenting the existing information for Ohio and providing a cohesive picture of the cancer mortality rates and trends for the state from 1956-1983 and placing it in the context of the national rates and trends. Some of the questions specifically addressed here are:

(a) What are the major anatomical sites contributing to the cancer deaths in Ohio in the past 28 years?
(b) What are the temporal dynamics of the cancer mortality rates?
(c) How do the rates and trends compare and contrast among racial groups and sexes?
(d) Are there clear patterns in the geographic distribution of rates in Ohio?
(e) How do the Ohio rates and trends compare with those for the nation?
(f) What will be the cancer mortality rates for Ohio by the year 2000, if the existing trends prevail?

K.K. Namboodiri, PhD, is a senior researcher at the Comprehensive Cancer Center at the Ohio State University in Columbus.

It is hoped that like similar reports for other states,[9-10] these analyses will serve as a basic resource for cancer control in Ohio and complement the incidence statistics when the latter become available for the state.

Table 1
Distribution of the Estimated Number of Newly Diagnosed Cancer Cases and Cancer Deaths in Ohio For 1985 by Major Anatomical Sites†

	NEW CASES		CANCER DEATHS	
Site	Number	Percent	Number	Percent
Lung	7300	16.2	6100	26.6
Colon-Rectum	7100	15.8	3100	13.5
Female Breast	6300	14.0	1900	8.3
Prostate	4100	9.1	1200	5.2
Uterus	2800	6.2	600	2.6
Oral	1500	3.3	425	1.9
Leukemia	1400	3.1	800	3.5
Pancreas	1300	2.9	1200	5.2
Stomach	1200	2.7	150	0.7
Other Sites	12000	26.7	7425	32.4
All	45000	100.0	22900	100.0

† *1985 Cancer Facts and Figures, American Cancer Society*

MATERIALS AND METHODS

A. Mortality Data

The present study is based on the cancer mortality data for the period 1956-1983, collected routinely from death certificates in Ohio, as part of the national vital registration system centered at the National Center for Health Statistics. The data elements consistently collected over this period are: race, sex, county of residence, age, year of death and specific cause of death. The last item is coded following the conventions of the International Classification of Diseases (ICD) in their versions 6-9, corresponding to the specific time frames when newer versions were introduced and implemented. To ensure uniformity, the established comparison tables[6] were used to recode the causes of death for earlier periods, compatible to ICD-9. Also, those deaths with missing pieces of key information and those with residences outside Ohio were excluded from the analyses. County was chosen as a convenient unit for analyses because it was small enough to be homogeneous for environmental and geographic characteristics and yet large enough to yield fairly reliable mortality statistics. The national mortality statistics used for comparison are compiled from published reports.[3,6]

B. Population Data

Estimates of the "population at risk" needed for computing the rates were obtained from the U.S. censuses of 1950, 1960, 1970 and 1980. Linear interpolation or extrapolation techniques were used to estimate intercensal and postcensal population counts. Although more refined estimation methods incorporating different facets of population dynamics are available, the present approach is chosen because of its simplicity, minimum data requirements and, also, the availability of national statistics using similar techniques for comparison with Ohio statistics. The mortality and the population data were stratified by race, sex, county and age groups for computing the relevant statistics.

C. Statistical Methods

Race, sex, age and site-specific rates, as well as crude mortality rates, are used to describe the mortality experience of the unit of analysis and to collectively represent the mortality pattern of the population. Also, in order to facilitate comparisons between groups or time periods, the age-specific rates are adjusted for the effects of changes in age composition by the direct method,[11] using the U.S. 1970 population distribution as the standard. The standard errors of the adjusted rates are computed following the formulation of Chiang[11] for Ohio, and Keyfitz[12] for the U.S. The usual z statistics are used, assuming normal approximation,[13] for comparison of rates between the groups of interest.

In order to minimize yearly random fluctuation due to small numbers in several cells, after some preliminary analyses, the 28 year mortality data are collapsed into four time periods, each of seven year duration: 1956-1962, 1963-1969, 1970-1976 and 1977-1983. These groupings are found to be adequate in yielding fairly stable temporal trends and are referred to subsequently as periods 1, 2, 3, and 4, respectively.

The temporal trends are assessed by graphic displays where the midpoints of the time series data are connected by curves smoothed by the spline techniques.[14] The projections of future rates for most categories are done by linear extrapolation of the time series data, under the assumption that the prevailing trends will continue into the future. For a few categories, in order to avoid negative estimates or in consideration of non-linearity, an exponential model is used to derive the estimates. It should be noted that because of this simple scheme used, the projected rates do not reflect the dynamics of the population at risk or the possible changes in incidence and survival, which in turn will impact on the mortality rates.

Urban-rural differential in cancer mortality is examined using the proportion of urban population in each country, as defined for the 1980 census.[15] Briefly, these comprise all persons living in urbanized areas (i.e., a central city or cities and surrounding closely settled urban fringe that together have a minimum population of 50,000). The average cancer mortality rates for counties falling within each quartile of this urban index are computed to examine any gradients in the rates. Also, product moment correlations between the urban index and mortality rates for counties are used to assess the significance of the associations.

Correlation and regression techniques were also used to relate the percent changes over time for different anatomical sites jointly, for specific groups of interest.

RESULTS

In this report, we attempt to give only the highlights in the rate and trend patterns of cancer mortality in Ohio. Detailed county and site specific rates and trends are compiled in a separate report.[16]

Table 2
Distribution of Cancer Deaths in Ohio: 1977-1983 By Race, Sex and Sites

	Deaths		Percent Distribution Within Race-Sex Groups			
	Total		Whites		Non-Whites	
Site	(7-Year)	Percent	Male	Female	Male	Female
Esophagus	2854	2.0	2.4	1.0	5.2	2.3
Stomach	4491	3.1	3.3	2.5	4.4	4.2
Colon	17244	11.9	10.6	13.8	8.3	12.9
Rectum	3433	2.4	2.5	2.3	2.0	1.9
Liver/gallbladder	3240	2.2	1.9	2.7	2.2	2.2
Pancreas	6883	4.7	4.5	4.8	4.9	6.2
Oral	2401	1.7	2.1	1.0	3.0	1.5
Bronchus/lung	37555	25.9	35.1	14.8	35.4	15.5
Prostate	7721	5.3	9.4	—	13.4	—
Breast	13364	9.2	—	20.0	—	18.6
Cervix Uteri	1774	1.2	—	2.5	—	4.5
Corpus Uteri	2211	1.5	—	3.3	—	3.7
Ovary	3917	2.7	—	6.0	—	4.2
Bladder	3683	2.5	3.4	1.8	1.7	1.8
Kidney	2896	2.0	2.3	1.8	1.5	1.5
Lymphosarcoma	4305	3.0	3.0	3.2	1.7	1.7
Leukemia	5547	3.8	4.1	3.8	2.8	3.0
Multiple myeloma	2196	1.3	1.5	1.5	2.1	2.6
Brain	3341	2.3	2.5	2.4	1.1	1.6
Other Sites	16218	11.2	11.6	10.8	10.3	10.1
TOTAL	145274	—	69579	60378	8895	6422

A. Distribution of Cancer Deaths

The estimated number of deaths for 1985 are given in Table 1. The actual number of cancer deaths for the most recent seven year period (1977-1983) and the percent distribution by anatomical sites for the race, sex strata are shown in Table 2. Overall, lung cancer claimed 25.9% of all cancer deaths. Among the males of both races, about 35% of deaths were due to lung cancer followed by colon cancer for whites (10.6%) and prostate cancer for non-whites (13.4%). Breast and lung were the two

major sites for females, claiming about 20 and 14.8 percent for whites and 18.6 and 15.5 percent for non-whites, respectively. Other sites which contributed to more than 5% of the cancer deaths are: prostate for white males, colon and esophagus for non-white males, colon and ovary for white females, and colon and pancreas for non-white females.

Table 3
Age-Specific Cancer Mortality Rates for Ohio and the U.S. (All Sites Combined)†

	WHITES				NON-WHITES§			
	Males		Females		Males		Females	
Ages	Ohio	U.S.	Ohio	U.S.	Ohio	U.S.	Ohio	U.S.
0- 9	6	5	4	4	5	5	3	4
10-19	6	5	4	4	5	6	4	4
20-29	10	10	7	7	8	10	9	9
30-34	17	16	19	18	16	18	21	25
35-39	30	27	39	35	42	45	49	51
40-44	58	56	72	69	92	111	110	102
45-49	122	119	136	125	231	235	176	174
50-54	247	231	219	208	409	436	281	274
55-59	411	385	313	299	680	673	409	387
60-64	674	619	444	414	1044	948	579	494
65-69	997	911	582	534	1358	1252	669	581
70-74	1371	1261	705	664	1827	1582	787	731
75-84	1885	1811	940	919	2352	2054	1045	925
>84	2348	2327	1256	1238	2732	2279	1348	1088

† *Rates per 100,000; Time periods represented have a midpoint of 1980 (Ohio: 1977-1983; U.S.: 1978-1981).*

§ *Non-white data for the U.S. pertain only to blacks, while Ohio rates include all non-whites, 90% of whom are black.*

B. Age-Specific Mortality Rates

The age-specific mortality rates which give a measure of the risk of dying of cancer within specific age groups are given in Table 3 for the race/sex categories in Ohio and the U.S. for the periods indicated. As has been well documented, the rates increase steadily with age. Except for the 30-49 age range, male rates consistently exceed the female rates. The gender difference is even more pronounced after 65. Among the race/sex groups, non-white males have the highest rates after 30 years of age. Comparing the Ohio rates with the national figures, although the time frame and the racial makeup of the groups are not strictly identical, there is a remarkable similarity in the rates within the subgroups. For most of the groups above 30, the Ohio rates appear to be consistently higher than the national rates. Further details of the site and age-specific rates and trends in Ohio are given elsewhere.[16]

C. Age-Adjusted Mortality Rates and Trends

The temporal trends in all-site cancer mortality rates for the race and gender groups in Ohio for the past 28 years are depicted in Figure 1. The non-white male rates are consistently higher and the increase steeper than those for the white males. The female rates are lower than the male rates and have experienced a decline in the seventies, but recently the trend appears to have reversed to a slow upturn for the white and a sharp upturn for the non-white females. Thus, whatever factors that contributed to the decline in female cancer mortality are being offset by more potent risk factors in recent years. When rates are pooled for the sexes, the non-white mortality rate is consistently higher than the white-male rates. In view of the differential temporal trends, however, sex-specific patterns seem more meaningful than the pooled rates.

Since the relative ranking of the Ohio rates for anatomical sites are of interest, these are graphically depicted for the race and sex groups for the recent period in Figures 2-5. These are shown in the same scale to facilitate easy visual comparisons. As is apparent, the gender differences overshadow the race differences.

For males (Figures 2-3), the ranking of major sites differ somewhat among the races, although lung cancer mortality ranks

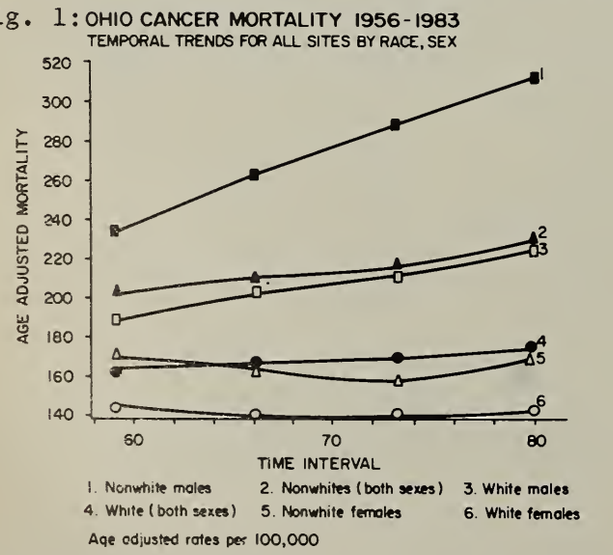
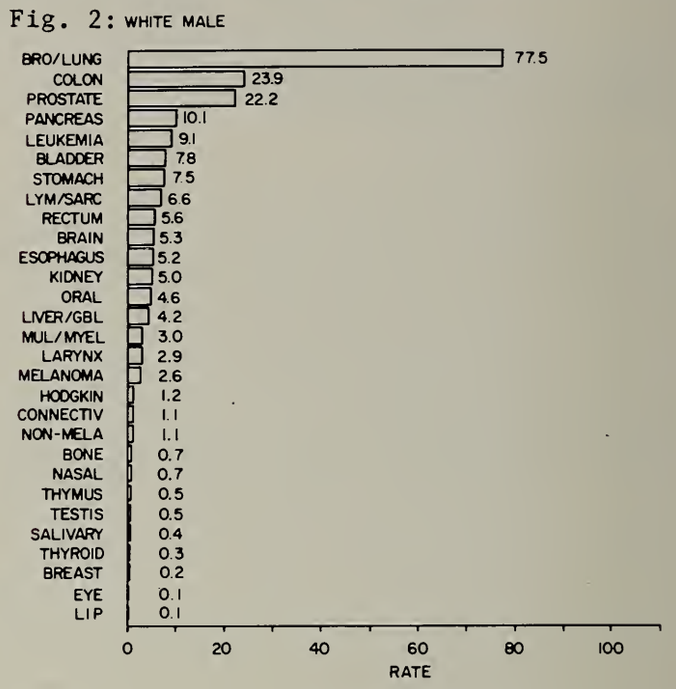
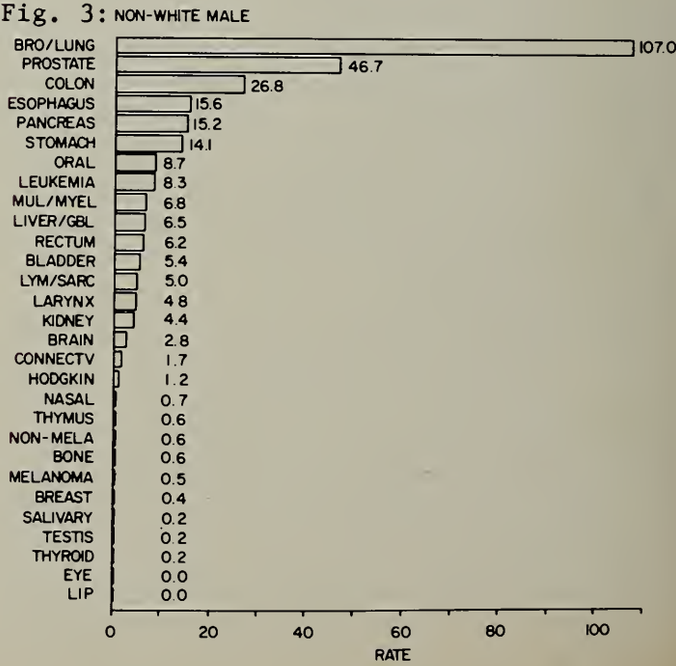


Figure 1. Temporal trends in cancer mortality in Ohio for the period 1956-1983 (all sites combined).



Figures 2-3. Cancer mortality rates per 100,000, ranked by anatomical sites, for Ohio white and non-white males respectively, for the period 1977-1983, adjusted to the U.S. 1970 Standard population.

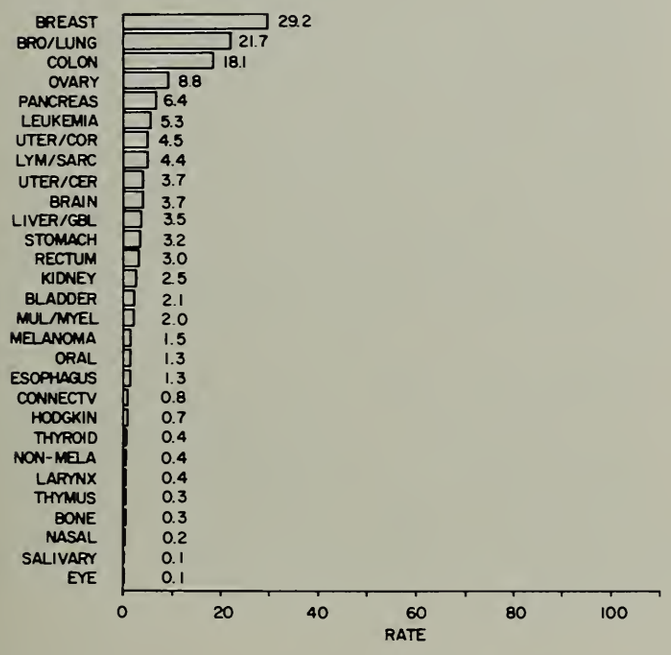


first in both groups. In the whites, colon is ranked second and prostate is third, while the reverse is true for the non-whites. For most sites the non-white rates are higher than those for whites: about three times higher for esophagus, about twice as high for prostate and multiple myeloma, more than 50% higher for stomach, oral, liver and pancreatic cancers, and about 30% higher for lung cancer. The few sites where the non-white rates are lower than the white rates are bladder, kidney, lymphosarcoma, leukemia, melanoma and brain tumors.

For female cancer mortality rates (Figures 4-5), the ranking of the first three major sites — breast, lung and colon — are consistent among the races. For most sites, the non-white rates are higher than their white counterparts. The exceptions are: cancers of the brain, ovary, lymphosarcoma, leukemia, and melanoma.

For the most recent period, for all sites combined, the male rates exceed the female rates by 59% and 85% for the whites and non-whites, respectively. Also, the overall non-white rates are higher than the white rates by 39% and 20% for males and females, respectively.

Fig. 4: WHITE FEMALE



Figures 4-5. Cancer morality rates per 100,000, ranked by anatomical sites, for Ohio white and non-white females respectively for 1977-1983, adjusted to the U.S. 1970 Standard population.

Fig. 5: NON-WHITE FEMALE

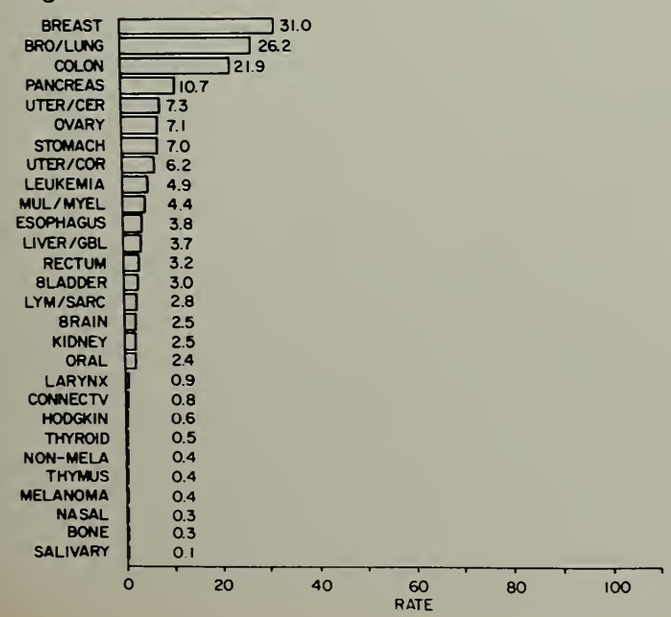


Table 4 gives the Ohio cancer mortality rates, standard errors and U.S. rates for selected sites for males by race. For a few sites, U.S. data were available only for an earlier period.[6] Omitting these, the Ohio and the national rates were tested for significant differences and the results are also shown in the table. For both races, all-site rates as well as those for lung, colon and rectum in Ohio are significantly higher than the national rates. It should be noted that the time periods involved for the U.S. and Ohio rates are not strictly identical although the midpoints of both are about 1980. Also, the U.S. data for non-whites in these comparisons are for blacks, while the Ohio non-whites are only 90% black. But since other non-whites are generally known to have lower cancer mortality rates than blacks,[3] contamination of such groups among the non-whites in Ohio can result, in general, only in a lowering of mortality rates. Thus the tests performed here for higher rates could be deemed more conservative than when using the Ohio data on blacks alone. So, with some limitations, the results of the comparisons made here are highly suggestive of anatomical sites, where further cancer control research and intervention are indicated.

Table 4
Adjusted Cancer Mortality Rates†
For Ohio (1977-1983) and the U.S. (1978-1981)
(Males)

	WHITES			NON-WHITES§		
	U.S.	OHIO		U.S.	OHIO	
Site	Rate	Rate	Standard Error	Rate	Rate	Standard Error
Esophagus∞	4.4	5.2	0.1	12.3	15.6	0.7
Stomach	7.7	7.5	0.1	14.8	14.1	0.7
Colon	21.1	23.9*	0.3	20.6	26.8*	0.9
Rectum	4.7	5.6*	0.1	4.5	6.2*	0.5
Liver/gallbladder∞	4.6	4.2	0.1	6.9	6.5	0.5
Pancreas	10.6	10.1	0.2	13.5	15.2	0.7
Oral∞	4.6	4.6	0.1	6.5	8.7	0.5
Larynx	2.6	2.9	0.1	4.9	4.8	0.4
Bronchus/lung	69.0	77.5*	0.5	91.4	107.0*	1.9
Prostate	21.1	22.2*	0.3	43.9	46.7	1.2
Bladder	6.9	7.8*	0.1	5.4	5.4	0.4
Kidney	4.6	5.0*	0.1	3.8	4.4	0.4
Lymphosarcoma	6.2	6.6*	0.1	4.2	5.0	0.4
Hodgkins∞	1.6	1.2	0.1	1.1	1.2	0.2
Multiple myeloma∞	2.7	3.0	0.1	4.6	6.8	0.5
Leukemia	9.0	9.1	0.2	7.4	8.3	0.5
Brain	4.9	5.3	0.1	2.5	2.8	0.3
All sites	209.5	223.9*	0.8	286.7	311.4*	3.0

† *Rates per 100,000 adjusted to U.S. 1970 Standard Population*
§ *Non-white U.S. rates, except for the sites indicated by (∞), are for blacks only. Ohio non-whites are 90% black.*
∞ *U.S. data for these sites are available only for the period 1970-1979. Since the periods are not very comparable, no significant tests were done for these sites between Ohio and the U.S. rates.*
* *Ohio rates significantly different ($P \leq .05$) from the U.S. rates.*

Table 5 gives the Ohio and U.S. mortality rates for the females of both racial groups for comparable time periods. The Ohio rates are significantly higher than the U.S. rates for all sites combined and also for breast, lung, colon and corpus uteri for both races. In addition, for white females, Ohio rates are higher than the national rates for rectum, cervix uteri, ovary, bladder and kidney cancers. The same caveats mentioned above for males are applicable here also, in the interpretation of the results.

D. Temporal Trends for Selected Sites

1. Comparison of Race, Sex Groups in Ohio

Trends of mortality rates over nearly three decades are graphically summarized in Figure 6 for some major anatomical sites. These depict how the relative ranking of the rates for the four race/sex groups have changed over time to the current rankings in decreasing order for most sites as non-white and white males followed by non-white and white females. The only exceptions to this among the sites shown are leukemia and ovary, where the whites surpass the non-whites of each sex, and pancreas, where non-white female

rates surpass the white male rates. Some highlights gleaned from individual site-specific trends are given below:

Table 5
Adjusted Cancer Mortality Rates† for Ohio (1977-1983) and the U.S. (1978-1981) (Females)

	WHITES			NON-WHITES§		
	U.S.	OHIO		U.S.	OHIO	
Site	Rate	Rate	Standard Error	Rate	Rate	Standard Error
Esophagus∞	1.2	1.3	0.0	3.0	3.8	0.3
Stomach	3.6	3.2	0.1	6.6	7.0	0.4
Colon	16.1	18.1*	0.2	17.6	21.9*	0.7
Rectum	2.7	3.0*	0.1	2.8	3.2	0.3
Liver/gallbladder∞	3.8	3.5	0.1	3.7	3.7	0.3
Pancreas	6.8	6.4	0.1	9.2	10.6	0.5
Oral∞	1.5	1.4	0.1	1.7	2.4	0.3
Larynx	0.4	0.4	0.0	0.7	0.9	0.2
Bronchus/lung	20.2	21.7*	0.2	20.1	26.2*	0.8
Breast	26.6	29.2*	0.3	26.3	31.0*	0.9
Cervix uteri	3.2	3.7*	0.1	8.8	7.3	0.4
Corpus uteri	2.0	4.5*	0.1	2.9	6.2*	0.4
Ovary	8.1	8.8*	0.1	6.4	7.1	0.4
Bladder	1.9	2.1*	0.1	2.6	3.0	0.3
Kidney	2.0	2.5*	0.1	1.7	2.5	0.3
Lymphosarcoma	4.3	4.4	0.1	2.5	2.8	0.3
Hodgkins∞	1.0	0.7	0.0	0.5	0.6	0.1
Multiple myeloma∞	1.8	2.0	0.1	3.1	4.4	0.3
Leukemia	5.2	5.3	0.1	4.6	4.9	0.3
Brain	3.3	3.7	0.1	1.6	2.5	0.3
All sites	132.7	140.6*	0.6	152.9	168.8*	2.0

See Table 4 footnotes.

a. Lung cancer mortality shows highest rates and increasing trends for non-white and white males and less dramatic but clearly increasing trend for females of both races. Although the female rates are relatively low compared to the males, the increase over the period is about 4-5 fold for the females compared to the doubling of the rates for the males.

b. Colon cancer mortality trends are noteworthy in the clear absence of any divergence in the rates among the sexes and in the declining trend for white females, as compared to the steady increasing trends of the other three groups. Although the whites had higher rates than the non-whites in the late fifties, the trend has reversed in recent times. Also, steeper rates of increase are noted for the non-whites. The declining trend for the white females is intriguing, although it parallels a similar national trend for this group.

c. Rectal cancer mortality shows a steady decline for all four groups over this time period, with the non-white rates exceeding the white rates in both sexes in the most recent periods. Although the possibility of mis-specification of sites in the large intestine, especially in the rectosigmoidal area, needs to be recognized, in view of the clearly opposing temporal trends of colon and rectal cancer mortality, it is important to report these sites individually and not as a combined rate. Moreover, unlike colon cancer rates, a clear difference in the rates among the sexes is apparent for rectal cancer mortality rates.

d. Stomach cancer mortality trend is a clear example of consistent decline over time, pervading all four segments of the population. The rate of decline has eased over the recent period, especially for the non-white females. The trends parallel the national trends, but the determinants of this decline are subject to much speculation. Possible factors are reduced exposures to dietary carcinogenic agents, reflecting changes in diet composition, food handling and storage methods over this period.

e. Pancreatic cancer mortality shows a difference in trends among the races. While the white males and females show a steady or even declining trend, the non-whites of both sexes have shown a recent increasing trend. Also, it is noteworthy that except for breast cancer rates, this is the only major site where a female rate has surpassed a male rate in Ohio. The reasons for the sharp upturn in rates for non-white females for this site need investigation.

f. Prostate cancer mortality rates for non-whites are nearly twice those of the whites. The gap between the races has widened in recent years because of the sharp increasing trend among the non-whites. Although the whites experienced a slight decline in the early seventies, the rates have been slowly increasing in recent years.

g. Esophageal cancer mortality rates show a striking contrast between the non-white males and the other three groups. The rates in the former are steadily increasing over time, while little change is apparent in the others. Similar increasing trends in non-white male rates are also evident for other smoking-related anatomical site cancer mortality, such as oral and laryngeal cancer.

h. Leukemia mortality rates are higher for whites than for non-whites. The rates show a declining trend in all groups except for the non-white females. The fluctuations in trends among the non-whites could be partly due to the small numbers of deaths involved for this disease.

i. Female breast cancer mortality trend shows whites with higher rates than non-whites in the earlier periods, but, in the most recent period, the non-white rates have surpassed the white rates. Also, while the trend for whites appears steady, the non-white rates are increasing.

j. Uterine cervix cancer mortality shows a dramatic decline in the non-whites and a slower decline for the whites. This has resulted in the narrowing of the racial differential, which was a predominant feature of the mortality for this site. The decline is at least partly attributed to the success of screening and early detection of cancers at this site using Pap tests.

k. Uterine corpus cancer mortality shows a similar pattern as the cervix cancer trends. For the white females cancer mortality at the site has in recent times exceeded that of cervical cancer mortality. Although the declining trends are similar, the rates of decline are slower for this site than those for the cervix.

l. Ovarian cancer mortality is higher among the whites than among the non-whites. The rates for both racial groups show a consistent decline over time. In spite of this decline, the mortality rates for this site remain higher than the uterine cervix and corpus rates in white women in the recent period.

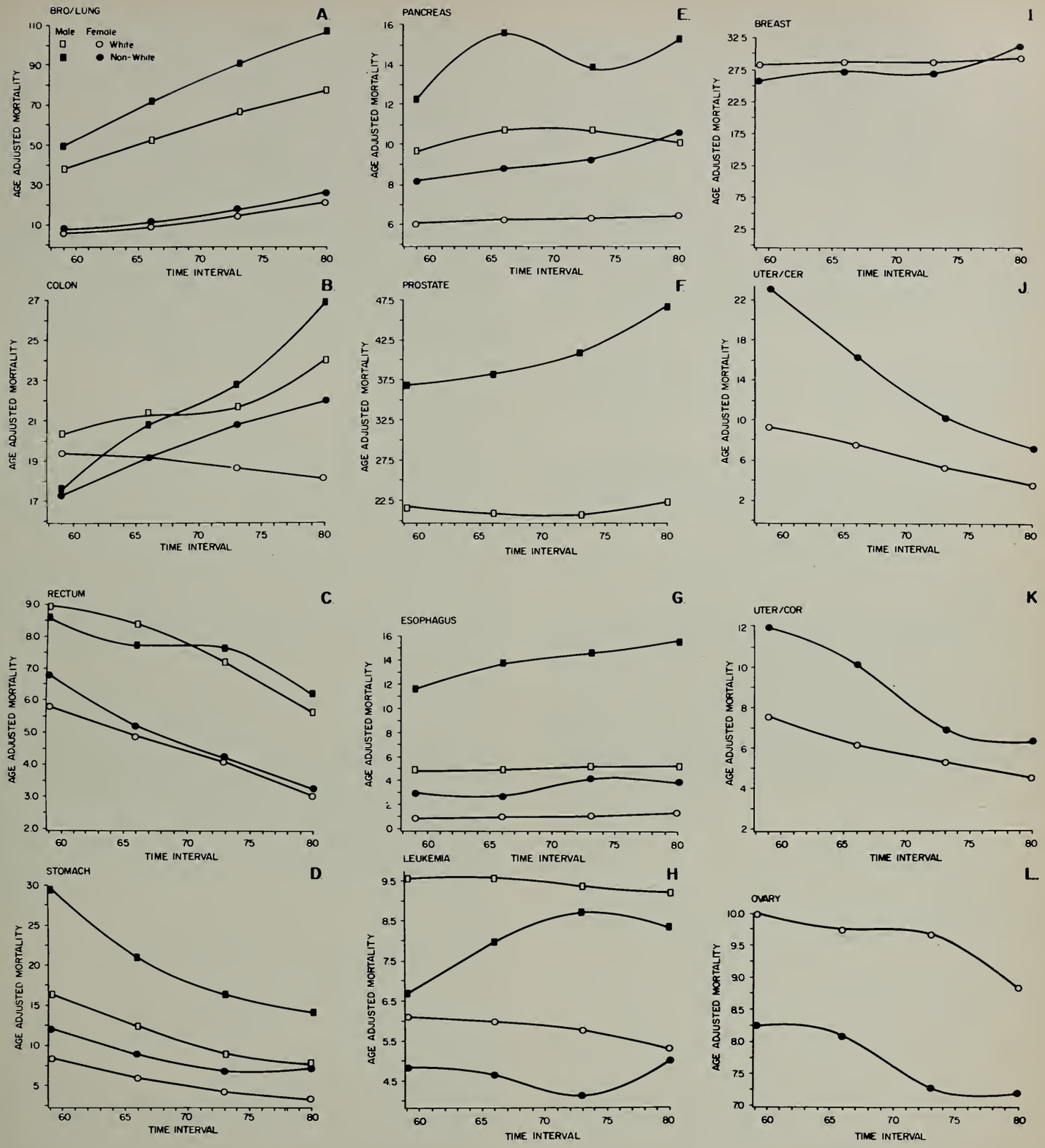
For the sake of brevity, temporal trends for other sites are not reported here, but are summarized elsewhere and are available on request.[16]

Comparison of Ohio and U.S. Cancer Mortality Trends

As short-term changes in rates for selected anatomical sites in Ohio are useful in comparing similar trends at the national level, the annual rates of change derived from the most recent two periods in Ohio and somewhat comparable periods for the U.S. are given in Table 6. For all sites combined, the change of rates in Ohio are higher than that for the U.S. for white males and non-white females, but are lower than that for the U.S. for white females and non-white males. For most sites, the increase or decrease and their magnitude are fairly similar in both Ohio and the U.S., although the rates of increase of lung cancer, especially among the white males and non-white females, are higher than those for the U.S. Another difference worth noting is the rate of change in breast cancer. While the national trend in whites is for a slight decrease, Ohio rates are slowly increasing in whites and increasing at a steeper rate among the non-whites.

In addition to comparing U.S. and Ohio rates for anatomical sites separately, using correlation and regression analyses, the similarity of the national and state trends was examined for different sites jointly. The correlation estimates of .81, .89, .82 and .69 for white males and females and non-white males and females, respectively, are highly significant indicating that site by site changes in Ohio closely parallel those of the nation. The fit of the linear models is excellent. A study of the residuals from regression suggest sharper changes in Ohio as compared to the nation for the following sites: pancreas for non-white males and kidney for non-white females.

Fig. 6. Temporal trends in cancer mortality in Ohio for selected sites: 1956-1983



E. County-State Comparison of Mortality Rates

Considering sub-area analyses within Ohio very briefly, mortality statistics are computed at the county level for all cancer sites combined for white males and females. The county rates are compared to the overall state rates for significant differences. Sub-area analyses for non-whites are not reported here because of the small number of deaths in several counties.

Figure 7 summarizes the county-state comparisons for all-site rates for whites. Counties where male and/or female rates are significantly higher than the state rates are indicated in the map. Although no clear regional clustering is apparent, there obviously is a concentration of higher cancer mortality rates in the urbanized areas of the state. Detailed site-specific comparison of county mortality rates is given elsewhere.[16]

Since an urban clustering of total cancer mortality is evident in Ohio, the association of site-specific cancer mortality rates and level of urbanization is examined for whites from county-specific data, following the criteria described earlier. The results — correlations and average rates for quartiles of the urban index — are given in Table 7 for males and females. A consistent positive association is seen between cancer mortality rates for all sites combined and levels of urbanization for both sexes. A clear increasing gradient in rates with increasing urbanization is also evident for lung and colon cancers and female breast and ovarian cancers. A reverse gradient, i.e. higher rates in rural than in urban areas, is noted for several rarer sites: salivary and nasal

Table 6
Annual Rate of Change in Cancer Mortality in Ohio (1970-1983) and the U.S. (1973-1981) for Selected Anatomical Sites†

SITE	MALES				FEMALES			
	Whites		Non-Whites§		Whites		Non-Whites§	
	Ohio	U.S.	Ohio	U.S.	Ohio	U.S.	Ohio	U.S.
Stomach	−0.20	−0.22	−0.32	−0.38	−0.12	−0.12	0.05	−0.10
Colon	0.34	0.20	0.58	0.46	−0.07	−0.04	0.17	0.20
Rectum	−0.22	−0.18	−0.20	−0.18	−0.10	−0.10	−0.14	−0.12
Pancreas	−0.08	−0.08	0.21	0.02	0.02	0.02	0.20	0.16
Bronchus/lung	1.61	1.00	2.27	2.22	0.99	0.96	1.27	1.00
Prostate	0.23	0.12	0.84	0.74	—	—	—	—
Breast	—	—	—	—	0.10	−0.06	0.62	0.08
Cervix uteri	—	—	—	—	−0.24	−0.16	−0.43	−0.48
Corpus uteri	—	—	—	—	−0.11	0.04	−0.09	0.04
Ovary	—	—	—	—	−0.12	−0.10	−0.01	−0.04
Bladder	−0.01	−0.10	−0.19	−0.06	−0.04	−0.02	−0.07	−0.04
Kidney	−0.01	0.02	−0.04	0.08	0.04	0.00	0.10	0.02
Lymphosarcoma	0.06	0.06	0.05	0.00	0.04	0.04	0.02	0.02
Leukemia	−0.02	0.00	−0.05	0.04	−0.06	0.00	0.12	0.04
All sites	1.86	1.02	3.47	4.20	0.32	0.42	1.69	1.00

† *Change of the rates per 100,000 adjusted to the U.S. 1970 Standard Population. Source of U.S. data from (3).*

§ *The non-white data for the U.S. pertain to blacks only; Ohio non-whites are over 90% black.*

cancer, testis, Hodgkins, non-melanoma and thymus in both sexes and melanoma in females. These could be related with increased exposures to sun and/or farm-related chemicals in the rural areas. In any event, several hypotheses can be generated and investigated from these findings.

F. Ohio Cancer Mortality Rate Projections for the Year 2000

In as much as we have only cancer mortality data and do not have information on incidence of new cases across Ohio, it is impossible to accurately determine the future risk of dying of cancer, since the case/fatality ratio depends on changes in a variety of health care delivery situations, as well as marked changes in risk factor level exposures in the future. However, if we make the simplifying assumption that no dramatic shifts in these factors are likely to occur and the prevailing trends for each site will continue at the same pace, some estimate of the cancer mortality rate arbitrarily for the year 2000 could be made. Thus linear models are fitted to the time series data for selected sites and the rates are extrapolated for the year 2000. These estimates for the race/sex strata are given in Table 8. It should be borne in mind that these are crude approximations and are given only as guides to aid in the planning of health care programs for cancer prevention and control.

Based on these projections for the year 2000, the non-white cancer mortality rates for all sites will increase by about 23-24% of the 1980 levels in both sexes. While the increase is about 14% for white males during the period, it is lowest (about 5%) for white females. With the current trends, lung cancer will soon rank as number one site for cancer death in females of both races. Dramatic increases in lung and prostate cancer for non-white males are also indicated. Continued declines in uterine and ovarian cancer in females are offset by the increases in lung cancer mortality. Thus these estimates give a framework for targeting, planning and implementing effective intervention programs to reduce cancer mortality in Ohio.



Fig. 7
Ohio counties with significantly high cancer mortality rates compared to the state and national rates: 1977-1983

DISCUSSION

Studies of rates and trends in cancer mortality over time in defined populations can provide etiologic clues by linking changes in known environmental exposures to the site-specific outcome. But caution has to be exercised in attempting to explain the findings in terms of etiologic factors because these would only be broadly speculative in nature. Moreover, several inherent problems with the estimates should be recognized. Both the mortality data and the population data are subject to potential sources of error. Although the mortality data are considered to be far more reliable than available incidence data, they are subject to: (a) incorrect or missing site specification, (b) errors in coding and/or transcription of cause of death codes due to changes in definitions over time and (c) problems related to incomplete ascertainment. The population at risk is also subject to error primarily due to underenumeration, especially for certain segments such as the non-white males of the population. Also, the linear interpolation techniques used for intercensal estimates do not take into account the complex facets of population dynamics. In spite of these potential problems, such data and methodology are widely used and the results are considered reliable since studies which examined the relative accuracy of different estimations[17] have found no significant differences in the rate or trend pattern. Since a small number of deaths can result in unstable trends, the seven year cumulation of deaths has alleviated this problem to a certain extent for the non-whites. However, the trends for the non-whites have to be interpreted with caution because of the possible heterogeneity of this group.

In spite of the decreasing trends in several sites, the all-site and the lung cancer rates are increasing at a rapid rate in Ohio. The urban concentration in excess cancer mortality has been observed in other studies as well.[18] The determinants of this clustering is subject to much speculation. Possible factors are: (a) those related to improved medical diagnosis and referral, (b) those related to stress and lifestyle in urban areas and (c) those related to exposure to agents, pollutants, emissions, etc. in the urban environment. It is also possible that some of these factors interact synergistically with occupational exposures[19] to exacerbate the problem. In any event, the present association analyses by site give clues to the sites and areas that could be most benefited by intervention programs.

Finally, the present analyses pave the way for formulating several research questions and strategies for cancer control in Ohio. For instance, urban areas should be the target of aggressive cancer control programs for several major sites. Lung cancer mortality is climbing rapidly in all segments of the population and should be effectively intervened. Non-whites, especially non-white males, emerge as the highest risk group for cancer mortality, especially for smoking-related sites and prostate cancer. Factors related to increase in kidney and pancreatic cancers in non-white women and those contributing to the increase in colon

Table 7
Urban-rural Associations in Cancer Mortality Rates For Whites in Ohio: 1977-1983†

SITE	MALES					FEMALES				
	r	Mortality Rate for Counties				r	Mortality Rate for Counties			
		Rural	Mostly Rural	Mostly Urban	Urban		Rural	Mostly Rural	Mostly Urban	Urban
All	.47+	197.3	212.3	215.1	229.1	.42+	127.1	133.1	134.5	144.9
Esophagus	.12	5.0	4.8	5.0	5.9	–.05	1.6	1.2	1.4	1.4
Stomach	.18	6.4	5.8	6.5	7.9	.11	2.9	2.7	2.6	3.5
Colon	.43+	18.8	22.5	23.1	24.5	.10	16.5	18.4	18.1	18.7
Rectum	.14	4.7	5.1	5.7	5.2	.20	2.5	2.6	3.0	3.1
Liver/gall	.04	3.9	4.4	3.8	4.2	.01	3.1	3.8	3.2	3.8
Pancreas	–.04	10.5	9.6	9.4	10.3	.20	5.4	5.7	6.6	6.3
Oral	.08	4.1	4.0	3.7	4.7	–.10	1.7	1.2	1.0	1.5
Salivary	–.39+	1.2	.9	.7	.5	–.48+	.6	.6	.3	.3
Nasal	–.42+	2.2	.9	.7	.8	–.52+	.9	.6	.4	.3
Larynx	–.02	3.2	2.7	2.8	3.1	–.56+	1.5	.8	.6	.4
Bro/lung	.35+	66.3	72.8	74.2	82.0	.37+	17.6	18.5	20.1	23.3
Breast	—	—	—	—	—	.24*	26.7	26.9	27.5	30.3
Cervix uteri	—	—	—	—	—	–.08	3.9	4.5	3.9	3.5
Corpus uteri	—	—	—	—	—	.02	4.1	4.4	4.3	4.2
Ovary	—	—	—	—	—	.26*	7.7	7.8	8.3	9.3
Prostate	.08	20.5	22.2	22.7	21.7	—	—	—	—	—
Testis	–.43+	1.2	.9	.7	.6	—	—	—	—	—
Bladder	.16+	6.9	7.6	8.2	7.7	.05	2.2	2.5	1.7	2.2
Kidney	.21*	4.1	4.9	4.8	5.2	–.17	3.0	2.8	2.5	2.5
Lymphosarcoma	.08	6.0	7.1	6.5	6.7	–.07	4.8	4.5	4.2	4.6
Hodgkin	–.24*	1.8	1.7	1.3	1.2	–.45+	1.6	1.0	.7	.7
Mul/myelo	–.17	4.0	2.8	2.9	3.2	–.07	2.1	2.2	2.1	2.2
Leukemia	–.07	8.2	9.5	9.1	9.0	.16	4.7	5.3	5.0	5.5
Melanoma	.17	2.3	2.6	2.5	3.0	–.27*	2.4	1.5	1.7	1.4
Non-Melanoma	–.36+	1.9	1.6	1.2	1.2	–.34*	.9	.8	.5	.5
Thymus	–.50+	1.6	1.0	.8	.5	–.39+	.9	.7	.5	.4
Brain	.00	5.6	4.7	4.9	5.6	.08	3.4	3.8	3.8	3.9

+P < .01
**P < .05*
† *The counties in Ohio were ranked by the percent of rural population component. To assess any gradients in rates, average rates per 100,000, adjusted to U.S. 1970 Standard Population, for each quartile of the rural population distribution are computed. Product moment correlations (r) between the measure of urbanization and mortality rates for each site are also given to show the significance of the realtionship.*

cancer need to be investigated.

To fully appreciate the cancer burden for Ohioans, these mortality results should be augmented by cancer incidence and survival data, since cancer morbidity depends on those two indicators, and many sites which have excellent survival potential will not be represented in the mortality statistics. Thus it is important to complement the present analyses with additional health status indicators to get a cohesive picture of cancer patterns in Ohio.

Table 8
Cancer Mortality Rates for Ohio Projected for the Year 2000 for Selected Anatomical Sites†

SITE	MALES		FEMALES	
	Whites	Non-Whites	Whites	Non-Whites
Stomach+	4.6	9.3	1.7	2.3
Colon	26.7	35.1	17.1	26.6
Rectum+	2.8	3.5	1.3	1.5
Pancreas	10.9	17.4	6.8	12.4
Bronchus/lung	116.3	163.8	36.1	43.1
Prostate	22.3	54.9	—	—
Breast	—	—	30.1	34.5
Cervix uteri+	—	—	1.3	2.8
Corpus uteri+	—	—	2.9	4.8
Ovary+	—	—	6.8	6.9
Bladder	8.4	5.8	1.4	1.3
Kidney	5.9	5.5	2.8	2.3
Lymphosarcoma	6.8	5.1	4.5	2.9
Leukemia	8.3	10.4	4.7	4.6
All sites	256.2	385.2	147.2+	207.7+

† *Rates are per 100,000, adjusted to the U.S. 1970 Standard Population. Projections are based on linear extrapolation of the time series data. A few exceptions are indicated below.*
\+ *Projections for these categories are obtained by fitting the exponential model* $P_{t1} = (P_{t0})(e^{rt_1})$, *where ti (i = 0, 1) represent time periods,* P_{ti}, *the adjusted rates and r, the rate of change. This avoids negative estimates and takes into account the nonlinearity and the recent upward trend for all site rates among the females.*

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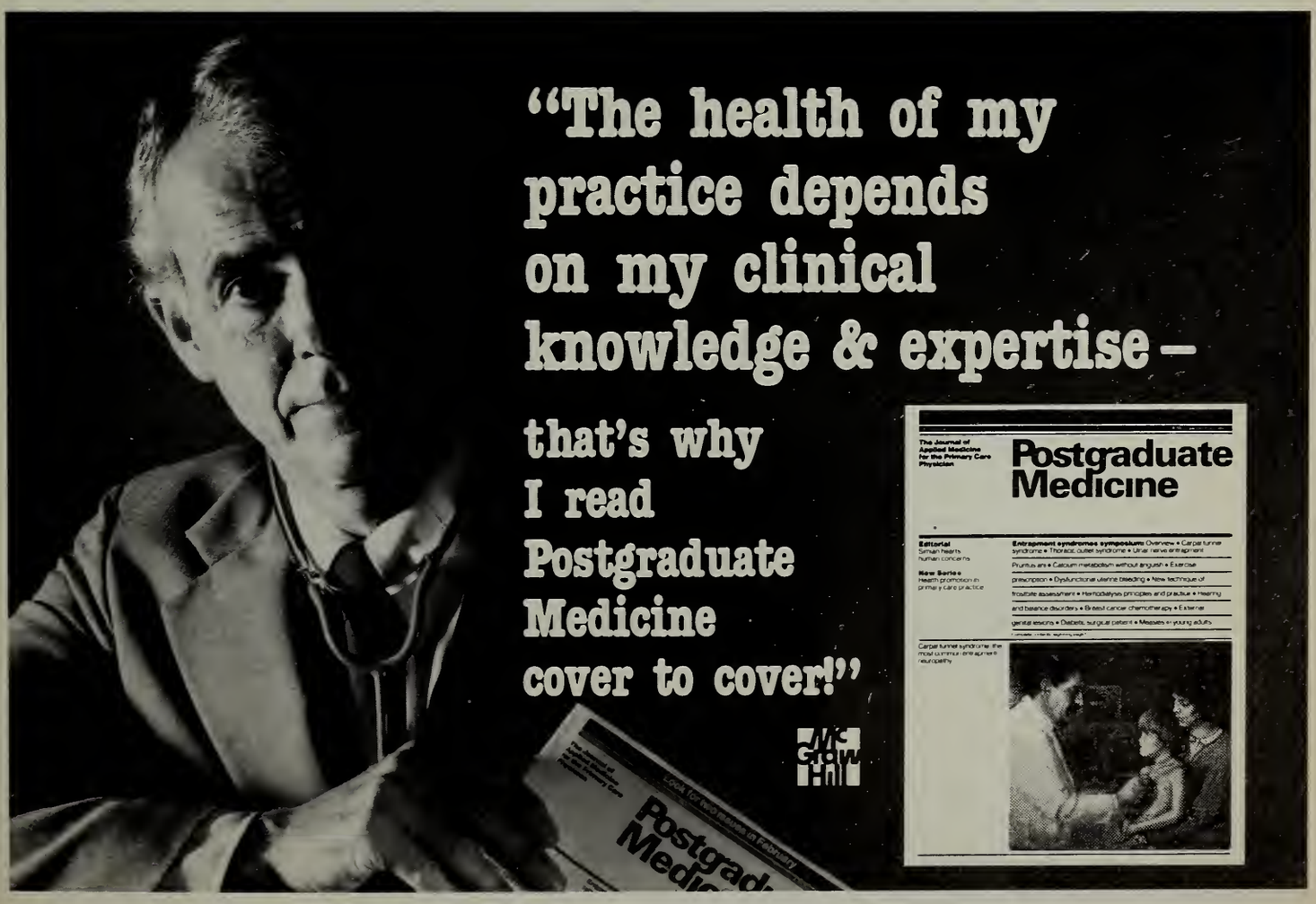
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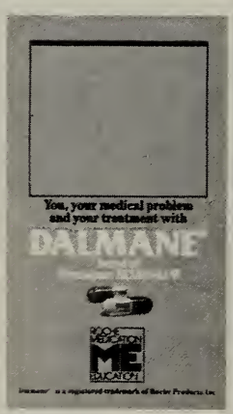
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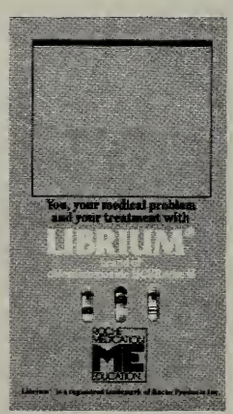
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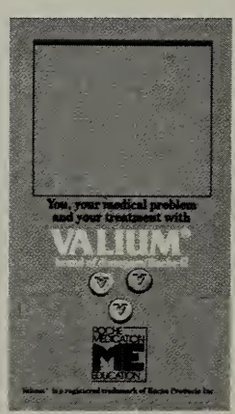
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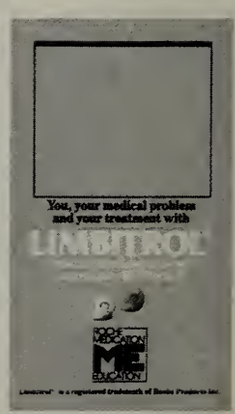
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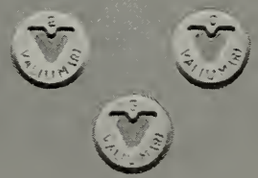
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Malpractice Legislation Introduced in House

By Kent Studebaker
Associate Director of Legislation

House Bill 1025, Ohio's medical professional liability bill, was introduced in the Ohio House of Representatives on September 10, 1986, by State Representative Paul Jones of Ravenna, Ohio. This bill, endorsed by the Ohio State Medical Association, the Ohio Hospital Association and the Ohio Osteopathic Association, specifically addresses those aspects of Ohio tort law which impact the practice of medicine.

John E. Albers, MD, President of the OSMA, had this to say regarding Representative Jones: "As Vice Chairman of the Ohio House of Representatives' Health Committee, Representative Jones has taken the lead in addressing medical issues in Ohio. His introduction of HB 1025 demonstrates his commitment to both Ohio citizens and the state's physicians to maintain quality medical care. As President of the OSMA, I commend Representative Jones for his initiative in tackling this issue."

Representative Jones presented HB 1025 to the House of Representatives' Select Committee on Civil Justice on October 2, 1986. This is the same committee that held hearings on Senate Bill 330, the general tort and insurance reform bill which dealt with the more global issues of commercial and professional liability insurance.

In presenting HB 1025 to the Select Committee, Representative Jones said, "Eleven years ago, the citizens of Ohio faced a crisis which threatened one of the very foundations of their way of life — the availability of affordable high quality health care. During this crisis, physicians and hospitals alike faced the alarming prospect of being unable to find liability insurance coverage at any price. Many insurance carriers, facing a deluge of medical malpractice claims, opted to stop offering liability coverage altogether. Other carriers went out of business. Some physicians were unable to obtain coverage and faced the unpleasant choice of either leaving the practice of medicine or opting to 'go bare' — practice medicine without liability coverage."

Representative Jones went on to point out to the Committee that in 1975 the Ohio General Assembly stepped in to help resolve the medical liability problem with the passage of House Bill 682. This bill, which also was supported by the OSMA, was designed to stabilize the insurance industry by establishing more equitable guidelines for the filing of a malpractice suit.

However, as Representative Jones explained to the committee and as most physicians know from their own personal experience, much has happened in the ensuing 11 years which has seriously weakened the Ohio law resulting from HB 682 and created a need for new malpractice legislation.

Most physicians have experienced firsthand the growing public sentiment that medicine must be perfect and that "imperfect" results must be compensated. They have also witnessed the increasing tendency for the courts to grant large awards in these cases — on what often seems to be the weakest of grounds.

But many physicians are unaware that another force has been at work — undermining the effect of the original legislation.

In the 11 years since the passage of House Bill 682, the Ohio Supreme Court has seriously eroded the intent of the original medical liability statutes. This is particularly true in regards to the

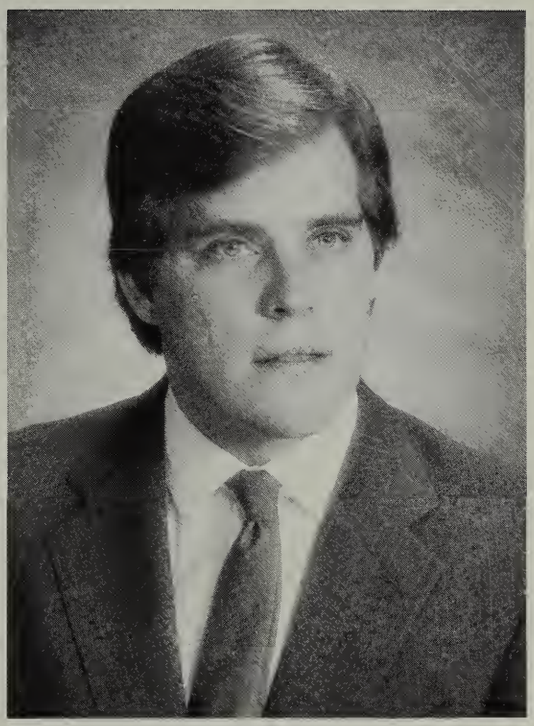
Court's treatment of the statute of limitations for medical cases. Starting in 1983, the Ohio Supreme Court has issued a series of opinions which have virtually eliminated the statute of limitations in this state. This has been done even though it is almost universally agreed upon that there must be a legally established statute of limitations in order to aid insurance companies to determine risk.

In addition to problems with the court's interpretation of the intent of HB 682, there have been other problems with the legislation. Certain sections of HB 682 have never been put into effect. For example, HB 682 requested the Ohio Supreme Court to establish a graduated maximum contingency fee schedule for attorneys. This has never been accomplished.

During his testimony before the House Committee, Representative Jones stated, "If House Bill 682 had been properly interpreted and enforced, as was set forth by the Legislature 11 years ago, it is possible that Ohio would not need additional malpractice legislation. However, this has not been done and it is becoming increasingly clear that the medical liability problem will not just go away. House Bill 1025 will accomplish this goal."

"As President of the OSMA, I commend Representative Jones for his initiative in tackling this issue."
— John E. Albers, MD
President, OSMA

Representative Jones went on to describe to the Committee the major provisions of House Bill 1025: It would clarify the statute of limitations in medical claim cases, clarify the effects of collateral sources of recovery,



Representative Paul Jones

Thanks to . . .

Ohio's medical professional liability bill, House Bill 1025, was introduced in the Ohio House of Representatives with 11 State Representatives as co-sponsors. Ohio physicians need to recognize and thank these individuals for their support of medicine in this critical issue. The House co-sponsors of House Bill 1025 are:

Rep. Paul Jones (D-Ravenna)
Rep. John Thompson (D-Cleveland)
Rep. Dean Conley (D-Canal Winchester)
Rep. Dale Van Vyven (R-Sharonville)
Rep. Dave Johnson (R-North Canton)
Rep. Vern Cook (D-Cuyahoga Falls)
Rep. Mike Shoemaker (D-Bourneville)
Rep. Robert Corbin (R-Dayton)
Rep. Louis Blessing (R-Cincinnati)
Rep. Ike Thompson (D-Cleveland)
Rep. William Batchelder (R-Medina)

Physicians are asked to write to the members of the House Select Committee on Civil Justice to express support for House Bill 1025. Members of the Select Committee are:

Rep. John Shivers (D-Salem), Chairman
Rep. Michael Stinziano (D-Columbus)
Rep. Barbara Pringle (D-Cleveland)
Rep. Otto Beatty (D-Columbus)
Rep. Robert Doyle (R-Beavercreek)
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"If H.B. 682 had been properly interpreted, it is possible that Ohio would not need additional malpractice legislation."

permit periodic payment of judgments and the itemization of awards, revise the doctrine of joint and several liability, establish a mechanism to discourage the filing of frivolous lawsuits, and establish a graduated schedule of attorney contingency fees.

The provision of the bill addressing the **statute of limitations** would apply to any medical or dental claim brought against a physician, nurse, dentist, podiatrist or hospital or its employees or agents. The bill would call for a lawsuit to be brought within one year from the time the patient discovers or should have discovered the injury. There is, however, an absolute bar to bringing a suit four years from the date the act or omission occurs. This provision of the bill confronts the current Ohio Supreme Court interpretations relative to the statute of limitations for medical claims.

The **collateral source** proposal would expand current collateral source statutes pertaining to medical claims to specify that damages awarded would be reduced by any payments made by any collateral source (e.g., Medicare, Medicaid, Worker's Compensation, Blue Cross/Blue Shield). However, the amount paid by the patient or the patient's employer to secure the insurance or benefit shall be added to the total award. The bill would provide that there would be no subrogation rights by any collateral source unless otherwise provided by statute.

The bill would establish a procedure for the itemization of awards and, in any case where future damages awarded for both economic and non-economic loss exceed $100,000, a procedure for **periodic payments** to be set by the court, if requested by either party to the suit. The bill would also require that at the death of the plaintiff, all future payments would cease.

House Bill 1025 proposes to reduce the number of **frivolous suits** filed in medical malpractice cases by establishing the procedure for filing an affidavit with the complaint. The affidavit would declare that a physician has reviewed the medical record and has found the medical claim to be reasonable. If the statements in the claim are found to be without reasonable cause and untrue, then the plaintiff and the plaintiff's attorney can be liable to pay for the defendant's attorney's fees.

The revision of the doctrine of **joint and several liability** is addressed by establishing a provision whereby no joint liability would exist for any defendant found to be less than 50% negligent. However, joint and several liability would exist for any defendant found to be 50% or more responsible and is a party at the time of judgment.

The bill would establish a **contingency fee** schedule for granting of attorney's fees to the plaintiff's attorney. This schedule would gauge the attorney's fee for the case to the amount of award made to the plaintiff in the case. The establishment of a graduated contingency fee schedule for attorneys is not a new proposal for medical claims cases. The Ohio Supreme Court was requested to establish such a fee schedule in the provisions of the 1975 medical professional liability bill. This, however, has never been accomplished.

Another provision of the bill would eliminate the awarding of punitive damages in a case involving a medical claim. The bill also reinforces the current statutory cap of $200,000 on general damages in medical claims, excluding wrongful death actions, by clarifying that general damages equate to non-economic damages. Non-economic damages are defined as any intangible loss, including pain and suffering.

The future of House Bill 1025 rests with the House Select Committee on Civil Justice. Hearings on House Bill 1025 will continue throughout the Fall.

Physicians are encouraged to contact members of the Select Committee to stress the need for tort reform in the area of medical professional liability before the Ohio situation reaches the same crisis proportions being experienced in other states.

The time for physician action is now.



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PAUL C. CRONE, MD, Cleveland; Case Western Reserve University School of Medicine, 1934; age 79; died August 5, 1986; member OSMA and AMA.

JOSEPH J. FINK, MD, Cleveland; St. Louis University School of Medicine, 1935; age 77; died August 26, 1986; member OSMA and AMA.

VERNON GOODWIN, MD, Vero Beach, Florida; Case Western Reserve University School of Medicine, 1935; age 75; died August 23, 1986; member OSMA and AMA.

ARTHUR HARBARGER, DO, Akron; Kirksville College of Osteopathic Medicine, Kirksville, Missouri, 1929; age 78; died August 14, 1986; member OSMA and AMA.

GEORGE L. HARGROVE, MD, Akron; University of Michigan Medical School, Ann Arbor, Michigan, 1928; age 84; died August 16, 1986; member OSMA and AMA.

WILLIAM C. MATTERN, MD, Sandusky; Ohio State University College of Medicine, 1975; age 35; died March 1, 1986; member OSMA.

JOSEPH PISCHIERI, MD, Hinckley; St. Louis University School of Medicine, St. Louis, Missouri, 1931; age 80; died August 7, 1986; member OSMA and AMA.

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THOMAS P. SCUDERI, MD, Akron; Loyola University Stritch School of Medicine, Maywood, Illinois, 1935; age 81; died September 5, 1986; member OSMA and AMA.

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OBERLIN, OH — 21 person multispecialty group seeks additional family physicians. Small college town near Cleveland. Salary and benefits leading to equal share in corporation after 1 year. Send CV to Dr. VanDyke, 224 W. Lorain, Oberlin, OH 44074; 216-775-1651.

OHIO: Emergency medical department directorship and full-time staff positions are immediately available at our newest client hospital located in one of the most prosperous counties in Ohio ideally situated between Columbus, Dayton and Toledo. Enjoy working in this moderate volume emergency department with full subspecialty backup and excellent nursing support. Guaranteed competitive income, outstanding CME allowance, occurrence malpractice insurance coverage, flexible scheduling, plus Medical Directors receive paid life, health, disability and dental insurance which includes dependents. For additional information contact Maggie O'Brien, Spectrum Emergency Care, PO Box 27352, St. Louis, MO. 63141; 1-800-325-3982; 314-878-2280.

OHIO: Emergency Medicine positions ranging from part-time placements to full-time Directorships. Low to high volume hospitals throughout the state. Guaranteed hourly rate plus malpractice insurance. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

OHIO, NORTHEAST/CLEVELAND: Staff position for Board Certified/prepared in emergency medicine or other primary care specialties for ED. 8000-32000 patient visits per year. Exc. compensation & benefit pkg: pd. health, life, disability, and dental ins; pension and PS plan; educ. stipend; and vac. Professional liability coverage paid by corp. Advancement to shareholder level for well-qualified individual. Please send CV to PO Box 2600, Lakewood, Ohio 44107.

OTOLARYNGOLOGIST: ATHENS, OHIO — Immediate practice opportunity available for board certified/eligible otolaryngologist in progressive, academic community. The hospital is fully accredited and equipped to accommodate a qualified otolaryngologist. The Athens community offers excellent school systems and outdoor activity. Primary service area includes population of 60,000. Please submit resume to Philip D. Kinnard, MD, Chief Surgery, O'Bleness Memorial Hospital, Hospital Drive, Athens, OH 45701.

OTOLARYNGOLOGIST NEEDED — for modern, progressive J.C.A.H. accredited hospital. Office space, adjacent to hospital, available. College town of 21,000 with drawing area of 40,000 population. Excellent schools, churches, diversified industry. Contact William C. Kelley, Jr., (419) 289-0491.

OTORHINOLARYNGOLOGIST, PSYCHIATRIST, ENDOCRINOLOGIST RADIOLOGIST AND GENERAL/ FAMILY PRACTITIONER
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PEDIATRICIAN — *Solo practice available immediately.* Modern, progressive J.C.A.H. accredited hospital. College town of 21,000 with drawing area of 40,000 population. Office space available. Contact William C. Kelley, Jr., (419) 289-0491.

PHYSICIAN MEDICAL DIRECTOR for rapidly growing ambulatory care center located in a new medical complex in Cleveland suburb. Excellent compensation package with paid vacation, paid professional liability insurance and advancement possibilities. Corporation is highly aggressive, staffing many emergency departments and urgent care centers in the Cleveland area. Training in primary care medicine preferred. Please send CV to PO Box 2600, Lakewood, Ohio 44107.

PHYSICIAN — Fill permanent full-time vacancy created by retirement in a long-term care facility. Contact Mr. R. Frum, Pers. Administrator, Ohio Veterans Home, Columbus Ave., Sandusky, OH 44870. (419) 625-2454, ext. 210.

PHYSICIAN WANTED to join busy, established family practitioner in a lovely college town in Central Ohio. Obstetrics optional. This is a satellite operation of a well-established multispecialty group practice just 18 miles distant. Shareholder status in the parent group available after the first year. Very competitive starting salary with superb fringe benefits. Please reply to PO Box 95, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, OH 43215.

PSYCHIATRISTS — Immediate openings for Staff Psychiatrists, full time and part time, board eligible/board certified, in a state-operated, JCAH accredited, 380-bed inpatient psychiatric hospital. Multi-discipline approach with psychiatrist as a treatment team leader, expected to exercise strong leadership in quality care of patients. Programs for acute admissions, extended care, geriatrics and psychiatric rehabilitation. License to practice in the state of Ohio is required. We are located about 20 miles from Akron, population: 300,000; excellent school system and outdoor activities. Massillon and adjacent Canton has a combined population of 110,000. Salary starts at $54,308 annually, with expected increase to $57,034 on 1/1/87. Excellent fringe benefits including paid vacation and personal leave, sick and educational leave, health, vision, dental and life insurance, etc. Travel costs may be negotiated. Faculty appointment to the Northeastern Ohio University College of Medicine possible for qualified applicants. EEO Employer, M/F/H.
Send resume to W.J. Roberts, Director of Personnel, Massillon State Hospital, Box 540, Massillon, OH 44648, or call (216) 833-3135, ext. 223.

URGENT CARE — COLUMBUS: Positions available with well-established Urgent Care Medicine Group that provides

coverage for three Urgent Medical Care facilities in Columbus. Six new facilities being built. Contact Primary Medical Associates, Inc., 340 East Town Street, Columbus, Ohio 43215, (614) 228-2253, 7:00 a.m.-3:30 p.m.

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DUE TO RETIREMENT. After the practice of general medicine for 50 years, I am offering the building, equipment and files for sale. Located in Southeastern Ohio, West Main Street, Morristown, Ohio 43759. For more information, contact: John Brown, MD, PO Box 165, Ph. 1-614-782-1381.

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Data processing hardware manufactured by Data General. System consists of Eclipse S-120 central processing unit, with 256 KB of memory and 50 megabyte hard disc, with reel to reel tape back-up system, five monochrome displays, and one Texas Instrument KSR Matrix Printer. In excellent condition, system is only two years old. Excellent system for small group practice or solo practitioner. For further information, please reply to Box 110, c/o Ohio State Medical Association, 600 S. High St., Columbus, OH 43215.

FOR SALE: Picker 2D Echo Cardiograph. Mounting on cart and cart. Picker Echo View 80C with H/P 1340A Display Model No. 595407-1. Picker Cardiac Imager Model No. 883034-3. Picker Monitor No. 882652-1. Sanyo Video Cassette Model VTC7100. Reply to: Lester S. Sherman, 3250 West Market Street — Suite 102, Akron, Ohio 44313 — (216) 836-0439.

FOR SALE: 4 Channel console with telemetry and all accessories for monitoring cardiac rehab patients. Like new condition. Please send reply to: Box 108, c/o Ohio State Medical Journal, 600 S. High St., Columbus, OH 43215.

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Medical Practice

ACTIVE MEDICAL PRACTICE FOR SALE: Practitioner retiring. Ideal for family practice or internist, solo or group. Inquiries PO Box 8144, Hyde Park, Cincinnati, OH 45208.

MEDICAL PRACTICE FOR SALE: M.D. practitioner retiring. Southeastern Ohio university town. Ideal for solo Family Practitioner or Internist. Reply to PO Box 112, c/o Ohio State Medical Journal, 600 South High Street, Columbus, OH 43215.

MEDICAL PRACTICE SALES AND APPRAISALS: We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our brokerage division at: The Health Care Group, 400 GSB Building, Bala Cynwyd, PA 19004 (215) 667-8630.

Position wanted

BOARD CERTIFIED CARDIOLOGIST (internist) Invasive-Non Invasive, Ohio and Kentucky licensed, wishes to join group or hospital in Cincinnati, Cleveland, Toledo. Reply to Box No. 97, c/o Ohio State Medical Journal, 600 S. High St., Columbus, OH 43215.

BOARD CERTIFIED INTERNIST-CARDIOLOGIST, Ohio and Kentucky licenses, seeks emergency room Cincinnati, Northern Kentucky. Reply to Box No. 98, c/o Ohio State Medical Association, 600 S. High St., Columbus, OH 43215.

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Mini-Residency beginning June 8-19, 1987 and continuing October 12-16, 1987 and March 14-18, 1988. Clinical & Administrative Occupational Medicine, Epidemiology & Biostatistics, Industrial Hygiene, Toxicology, Regulations, etc. 111 AMA Cat I, AAFP prescribed, Cat 2-D AOA and Cat I ACEP credits. 11th year. References from past participants provided. $650 per week. Sidney Lerner, MD, College of Medicine, Mail Location 182, Cincinnati, Ohio 45267-0182, 513-872-4043.

FOR SALE: ADR 4000 S/L Ultrasound Scanner. A linear transducer, additional monitor, polaroid camera. 1983 model, $12,000. Contact M.V. Koroly, 1900 23rd Street, Cuyahoga Falls, Ohio 44223.

Family practitioner needed in small rural Northern Ohio community. Practice established for 51 years. Two local tertiary hospitals, 12 miles. Three larger hospitals, 18 miles. Cleveland — Columbus — Toledo — 1½ hours away. Cross coverage easily arranged. Send inquiries to P.O. Box 215, Shiloh, Ohio 44878.

COLLEAGUES IN THE NEWS

Nino M. Camardese, MD, Norwalk, was recently named one of Ohio's top 10 naturalized citizens by Gov. Richard Celeste. Dr. Camardese left Italy in 1939 to come to the U.S.

Daniel A. Deutschman, MD, Cleveland, was installed as president of the Cleveland Academy of Medicine at its 1986 annual meeting. Other officers elected at the meeting include: Wilma F. Bergfeld, MD, president-elect; Melvin Shafron, MD, vice president; O. David Solomon, MD, secretary-treasurer; and Regina Dzurik, president of the Auxiliary. Ray W. Gifford, Jr., MD, received the Academy's top honor, the Distinguished Membership Award; Robert E. Brooks, MD, received the Clinician of the Year Award; and Distinguished Service Awards were presented to Thomas Redding, MD, and posthumously to Garry G. Bassett.

Robert B. Daroff, MD, director of the University Hospitals of Cleveland Department of Neurology, has been named editor-in-chief of *Neurology,* the official journal of the American Academy of Neurology.

Robert E. Fornal, MD, Beavercreek, has been selected for an Association for Academic Psychiatry (AAP) fellowship for 1986.

Louis J.R. Goorey, MD, a pediatrician from Columbus, has recently been elected president of the Children's Hospital Medical Staff for 1986.

Thomas J. Hall, MD, FACEP, of the Department of Emergency Medicine at Licking Memorial Hospital, has been appointed state medical director of the new Ohio Emergency Medical Services Agency.

William Kitzmiller, MD, Cincinnati, has been elected secretary-treasurer of the Noah Worcester Dermatological Society for 1986-87.

John D. Kramer, MD, director of cardiology at Children's Hospital in Akron, recently received a recognition award from the Department of Pediatrics at Akron's Children's Hospital and from Tod Children's Hospital at the Sixth Annual Pediatric Update for the Practicing Physician ceremony. Dr. Kramer was honored for his contributions and leadership as first chairman of the Department of Pediatrics. He was also honored with an award from the Summit County Children's Services in recognition of his commitment to first-rate medical care.

Daniel J. Lacey, MD, PhD, Dayton, has been appointed associate professor of neurology and pediatrics at Wright State University in Dayton.

R. Kenneth Loeffler, MD, FACR, Hartville, has received the Silver Medal for distinguished service from the Ohio State Radiological Society.

Harry R. Maxon III, MD, professor of radiology at the University of Cincinnati Medical Center and associate director of the Division of Nuclear Medicine, has been selected by the National Cancer Institute to work as one of three American clinical investigators in field investigations of chronic radiation in China.

Frederick T. Merchant, MD, Marion, recently received the First Annual Distinguished Service Award from the Federation of State Medical Boards of the United States. Dr. Merchant was recognized for his roles as former president of the federation, founding father of FLEX (Federation Licensing Examinations), and first chairman of the FLEX board.

John H. Rosemond, Sr., MD, a family physician from Columbus, has been named to the Family Network Advisory Board of *Better Homes and Gardens* magazine.

Kenneth W. Rowe, Jr., MD, an ophthalmologist from Cincinnati, has been named acting dean of the University of Cincinnati College of Medicine.

Albert Sabin, MD, developer of the oral polio vaccine, has been chosen by President Reagan to receive the Presidential Medal of Freedom, the nation's most prestigious civilian award. Dr. Sabin, formerly of Cincinnati, currently continues his medical endeavors at the Fogerty International Center for Advanced Health Sciences in Bethesda, Maryland.

Eugene L. Saenger, MD, professor of radiology and director of the Division of Nuclear Medicine at the University of Cincinnati Medical Center, has been appointed director of the multicounty Region I of the Cancer Control Consortium of Ohio.

Jack Schreiber, MD, a family practitioner from Canfield, has been appointed associate medical director of Physicians Health Plan, Columbus.

Medical student **Peter Spatt,** of Wright State University in Dayton, has been named assistant editor of *Pulse,* the AMA-MSS news magazine; and medical student **Cathy Yeagley,** of Ohio State University in Columbus, has been named Region IV representative to the AMA-MSS States Leadership Conference. Both are members of the OSMA Medical Student Section.

Nick L. Terezis, MD, Steubenville, has been reappointed as liaison fellow of the American College of Surgery's Commission on Cancer at the Ohio Valley Hospital.

George W. Waylonis, MD, Columbus, has been appointed vice president of the Flying Physicians Association for 1986-87.

Alfred L. Weiner, MD, Cincinnati, was recently honored at the rededication of the Noah Worcester Dermatological Society Science Library. Dr. Weiner, Emeritus Professor of Dermatology at the University of Cincinnati College of Medicine and founder of the Noah Worcester Dermatological Society, was recognized for his many medical contributions and activities.

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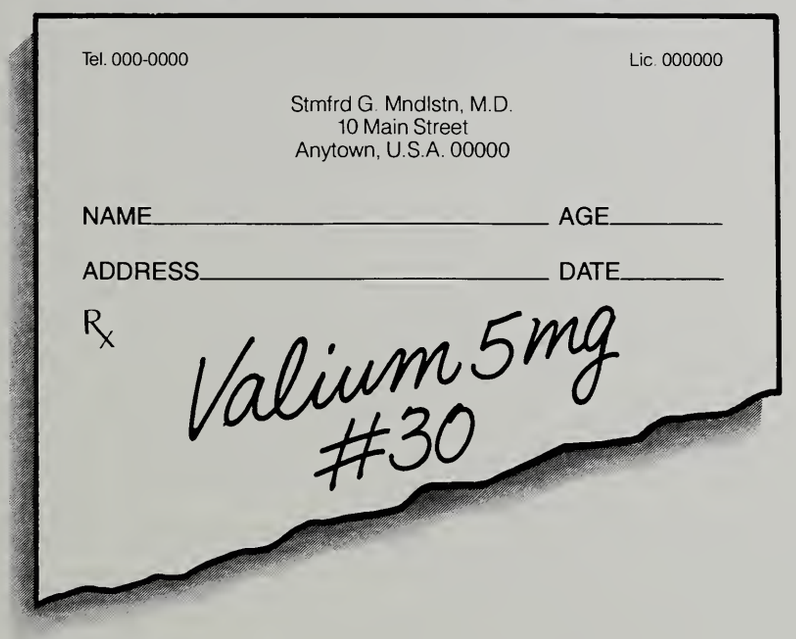
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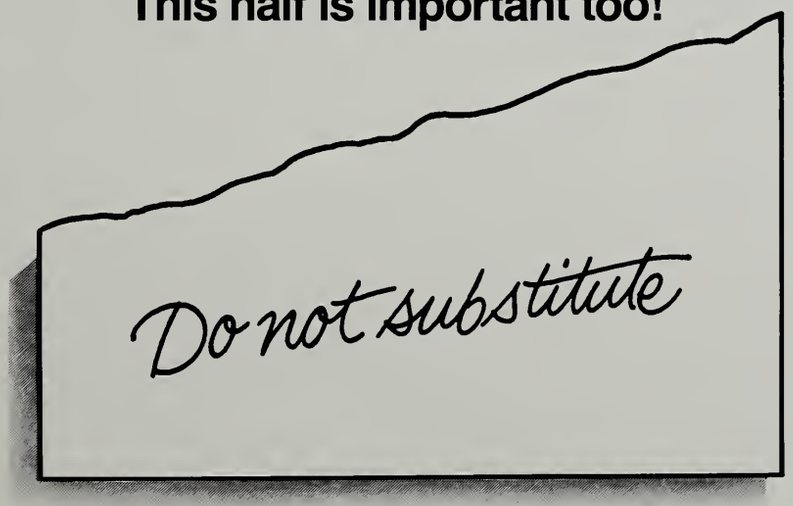
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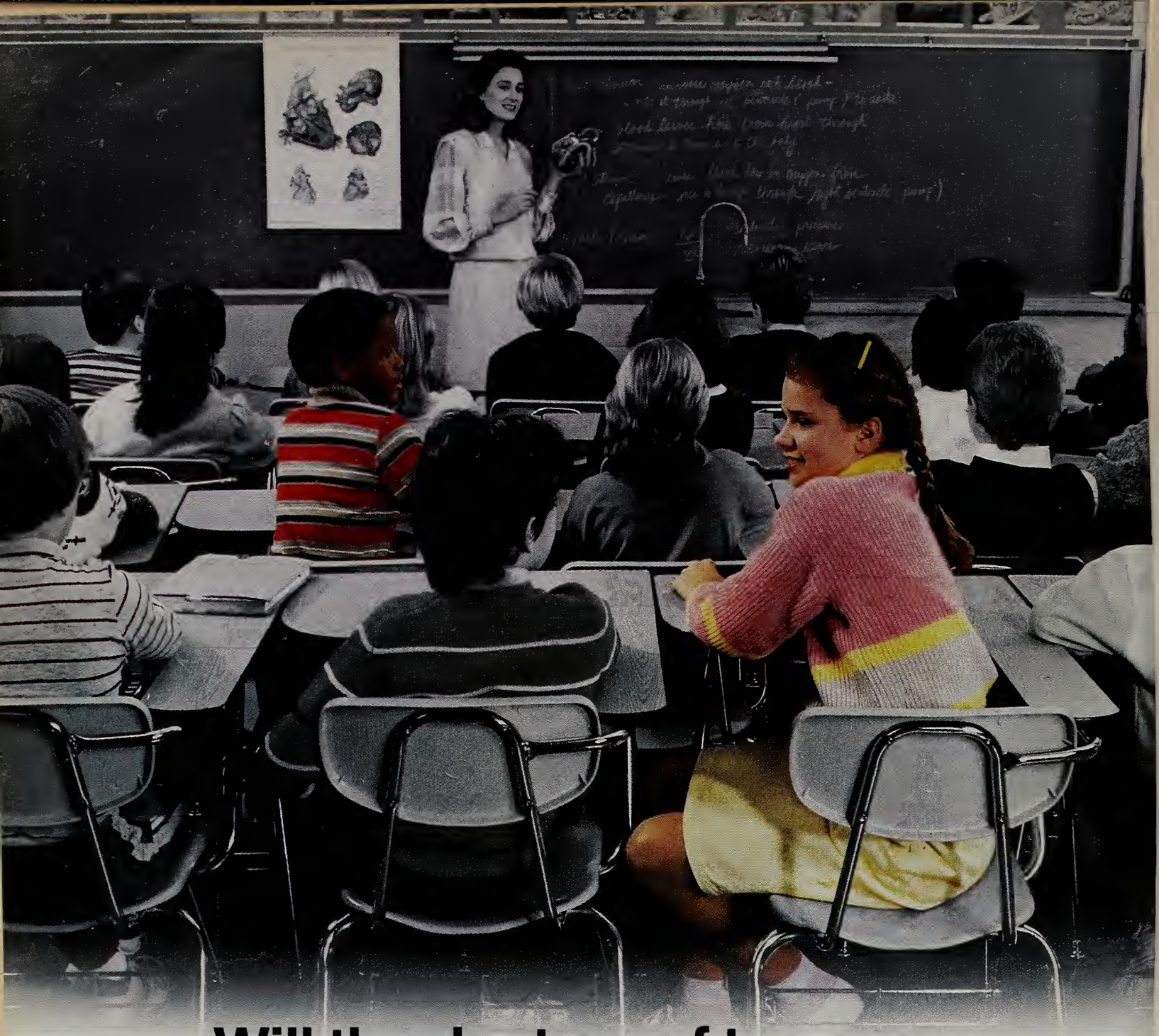


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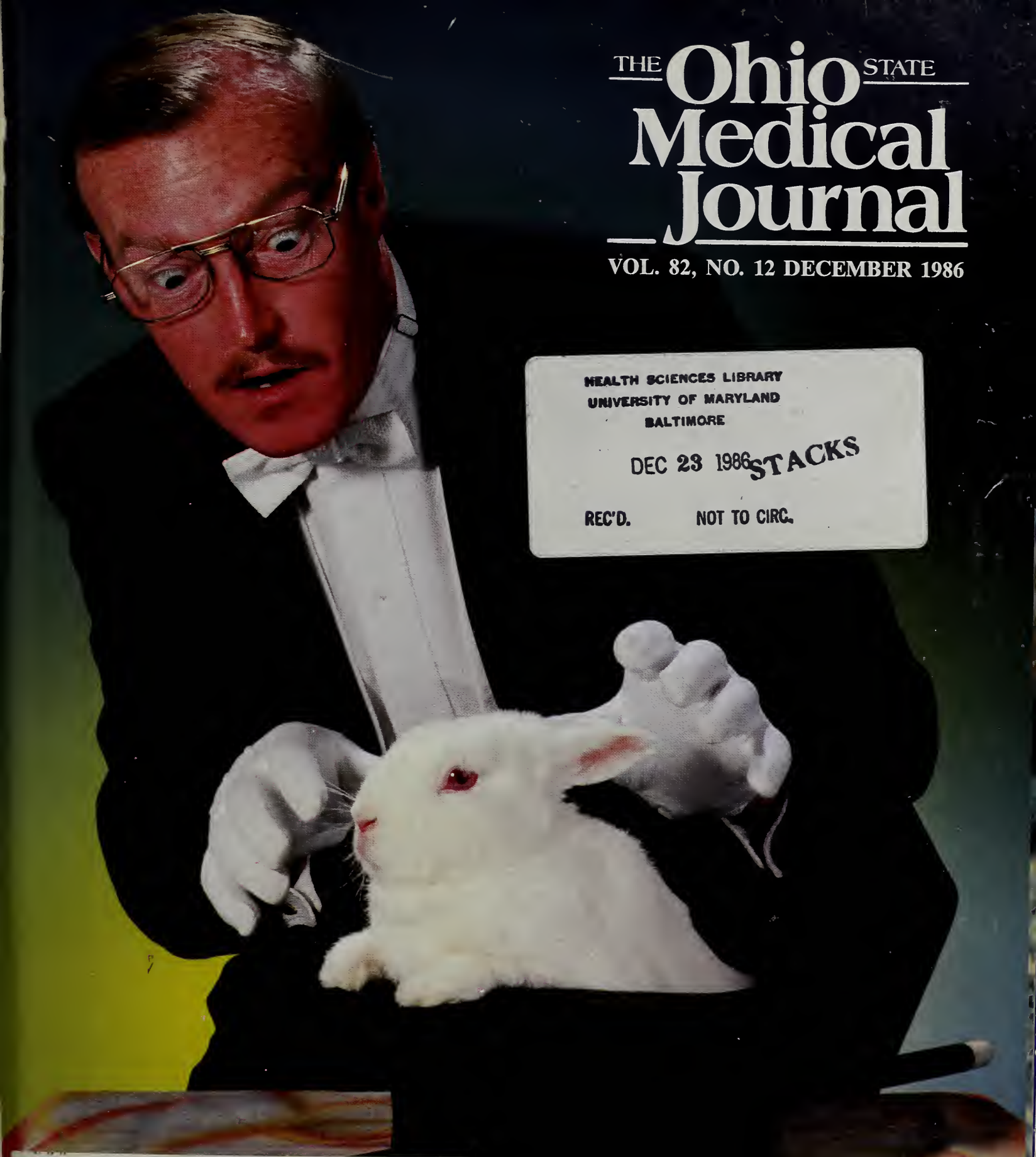
THE Ohio STATE Medical Journal

VOL. 82, NO. 12 DECEMBER 1986

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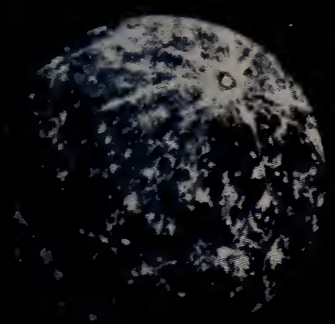
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References: **1.** Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.

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FROM THE EDITOR

Health fraud, eating disorders ... and what it's really *like to edit the* New England Journal.

You've seen them — the newspaper and magazine ads that claim their product "makes weight loss fast," "relieves arthritis pain" or "cures cancer." The trouble is, your patients are not only seeing these ads, too, but they're reading them — and taking them to heart. Health-care fraud is big business these days, and charlatans abound with potions and cures for every illness imaginable.

This month, Associate Editor Susan Porter moves in for a close-up look at health-care fraud — how and why it operates so easily today, and, more importantly, what can be done — and *is* being done — to stop it. We think you'll find it eye-opening.

Eye-opening, too, is an article on what it's *really* like to edit the *New England Journal of Medicine.* The NEJM's editor, Arnold Relman, MD, was in Ohio recently, and provided a candid view of life from the editor's chair. He also couldn't resist the opportunity to speak on a subject near to his heart — that of the physician as businessman — and you'll find his thoughts on that topic contained in this month's "Ohio Medi-scene" section.

Also in "Ohio Medi-scene" are stories about the health of today's American family, a write-up on a recent celebration of "elderlife," held in Cincinnati, and an article about eating disorders, written by Assistant Editor Deborah Athy, which delves into a subject of relative rarity — the male eating disorder victim.

You won't want to miss the article on "Silent Heart Attacks," nor the "Out of Practice" column, which features the off-duty — and historic — interests of a Springfield pathologist. And, this month, we indirectly salute Christmas by featuring a story about Charles Dickens (author of *A Christmas Carol*) and his life and times here in Ohio. That's right — Ohio. The article was written for us by James Ravin, MD, former chairman and still a member of the OSMA's Art and Culture Committee. It's a change-of-pace kind of article, and one we think you'll enjoy.

Speaking of change of pace, next month the *Journal* will feature, in this space, a guest editorial from the Chairman of our Advisory Board. There will be some surprises coming up for *Journal* readers in 1987 — but we'll let him tell you all about them. In the meantime, everyone here on the *Journal* staff joins me in wishing all of you a glorious and happy holiday season.

Karen S. Edwards

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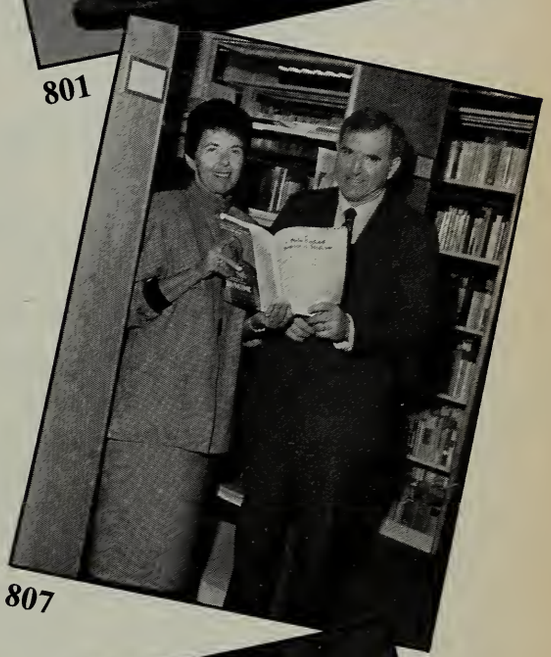
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JOURNAL COVER:

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WHAT YOU DON'T KNOW ABOUT ST. ANN'S WOULD FILL A HOSPITAL



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OPEN Needs Our Participation



By John E. Albers, MD

The OSMA has launched a new program, Ohio Project Elderly Needy, which I believe can be instrumental in providing much needed medical care to the poverty-stricken older citizens of this state.

According to the Ohio Department of Aging, there are an estimated 17,000 Ohio citizens, covered by Medicare, who live at or below poverty level. There are an additional 8,000 elderly, at or below poverty, who have no type of insurance coverage at all.

It is my concern, and the concern of William Marshall, MD, Second District Councilor, the developer of this program, that these elderly people, because of financial constraints, may not be receiving the medical care they need.

OPEN is designed to identify these elderly people and put them in contact with volunteer physicians who are willing to accept assignment for those patients with Medicare and to provide free office care to those patients with no health coverage.

I understand that there are physicians who believe the medical profession is already doing more than its share to underwrite the Medicare program. However, I strongly believe that we, as physicians, cannot overlook the humanitarian aspects of this endeavor. By providing this public service to the people who need our care and would otherwise not be able to afford it, we are fulfilling our role as physicians.

As important as the public service aspect of OPEN is, there are other aspects of the program which are just as important. For example, OPEN could potentially lower health care costs if a significant number of elderly people are identified and treated. The longer treatment is delayed, the more expensive it is to deliver. By getting needy elderly people into the health care system at the beginning of their illnesses, I believe we can have a definite impact on the cost of care.

OPEN could also prove to be an excellent way to *show* the public that we, as physicians, are vitally interested in the health of our elderly citizens. Actions do speak louder than words and this action can be an important step in showing our concern.

That concern may also serve as evidence to our legislature that we are capable, on our own accord, of tackling this problem. Physicians in other states are facing the unpleasant specter of having medical licensure tied to the acceptance of Medicare assignment.

I encourage you to speak to your county medical society leaders about participating in OPEN. Although OPEN is sponsored by the OSMA, it is designed to be implemented individually in each county, by the local county medical society.

That means each county medical society has the flexibility to set up the program to best suit its individual needs. However, since identifying those elderly people who qualify for participation in OPEN is vital to the success of the program, most counties will probably find it easier to work in cooperation with a local aging group or the local medical auxiliary.

Besides helping to notify potential participants regarding the program, these support groups can also register and screen participants. It is important to remember that OPEN is *not* designed for all elderly, it is available to the elderly needy only. People who register for the program must attest to the fact that they qualify for care by being at or below poverty level. Poverty level is being defined as an annual income of no more than $5,360 for an individual and an annual income of no more than $7,240 for a couple.

Thus far, two county medical societies have launched OPEN in their communities: the Montgomery County Medical Society and the Academy of Medicine of Toledo and Lucas County. I am pleased to report that the program is doing very well in both counties.

The OSMA worked with both Dayton and Toledo to develop the necessary registration forms, and to promote the program through the news media. It will provide this same type of assistance to all county medical societies who decide to participate in OPEN.

To be really successful, we must have all local societies participating in OPEN. With the interest and support of physicians statewide, we will be making a good faith effort to deal with a problem which confronts all of society. I urge you to participate.

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LETTERS TO THE EDITOR

The brains of leaders

To the Editor:

"The Brains of Leaders" by Lawrence Weinberger, MD *(OSM Journal,* September, 1986) is a terrible misuse of what should be a non-partisan journal.

Terrible. Frightening. Yes — I do remember propaganda, World War II, Hitler, Goebbels and subsequent national and international mind benders. I strenuously object. A political and propaganda forum? Please, not the *Ohio Medical Journal.*

Sincerely,
Marvin F. Dees, MD
Mansfield

To the Editor:

Neither I, nor any dermatologist, is enchanted with Dr. White's speculation and Dr. Lawrence M. Weinberger's approval of an "Hour Glass" (intracranial extension) of Mr. Gorbachaev's superficial port wine stain (*OSM Journal,* September 1986).

Since I started an invitation proposal to Mr. Gorbachaev (sent by the White House to the Russian Desk at the State Department, then finally to the Russian Embassy), I should like to continue my ineffectual offer. The purpose of this invitation was to get proper treatment for this superficial mark, a type of treatment which would not be available in Russia. (I had lectured in Russia on the laser treatment of vascular lesions.) Then, after these treatments, Mr. Gorbachaev could claim he would, at least, get something out of his American trip. Much to the disappointment of some Russian emigre anaesthesiologists at the hospital, Mr. Gorbachaev is not the least bit interested in getting his mark of distinction treated. His spot is of cosmetic interest since it is superficial and is not the deep angioma type which would go intracranial. As one gets older, port wine stains bulge superficially through connective tissue changes, not through any endothelial cell proliferation or malignancy. So he can keep it in good health, which he so desires. Just observe him as the mark gets redder in debate, this, without pounding his empty shoe. So, since he is too proud to cover it up with Dermablend now, the unwary listener focuses his attention on this beacon light and not directly, and more importantly, on this tough cookie himself.

Leon Goldman, MD

(Who is not retired from practice and who is Director of the Laser Research Laboratory and the Laser Treatment Center. He knows about port wine stains, as any dermatologist, since he was once Professor of Dermatology at the College of Medicine at the University of Cincinnati. He is now Professor Emeritus, or considered by some, as Professor Dermeritus.)

The consumer movement and Ralph Nader

To the Editor:

There is an unstated syllogism in American thought that goes something like this: "Consumerism is good. Ralph Nader is the founding father of comsumerism. Therefore anything Mr. Nader says is good." Physicians and others familiar with current tort law problems may have trouble accepting that line of thought after reading the report of his recent Cincinnati speech in the September issue of the *Journal.*

The consumer movement has matured in the days since Nader slew the Corvair, but his sweeping, simplistic assault on the insurance industry gives us reason to doubt that he has matured with it. His attack ignores the multiple roots of the liability insurance crisis and does nothing to help us solve it. The search for a cure must be much more broadly based, looking at the law, legal ethics, professional performance and public relations, and our basic human values.

Sincerely,
Robert D. Gillette, MD
Cincinnati

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A Medical Student's Thoughts on the Future of Medicine

To the Editor:

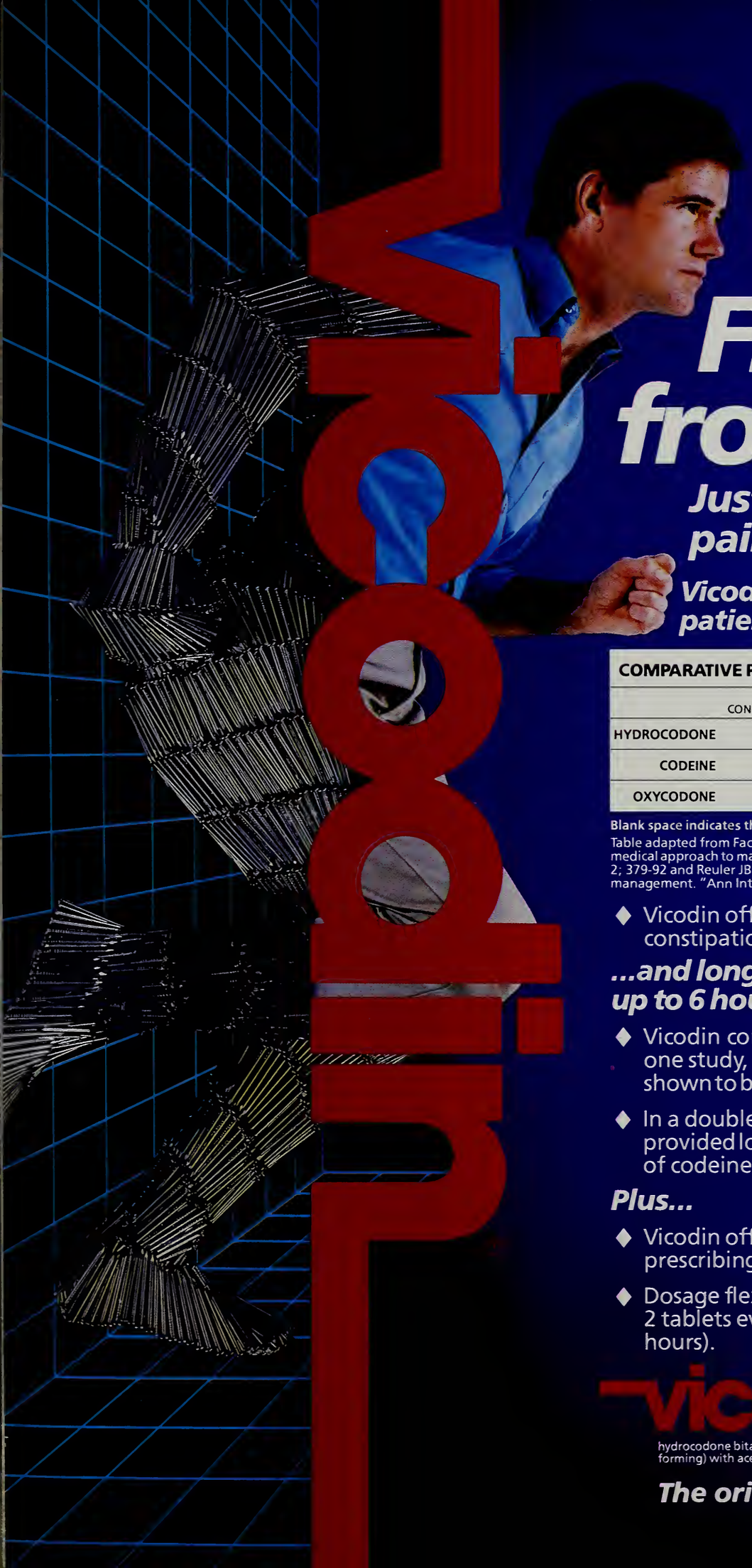
For the past three years I have read your publication and enjoyed the articles each month, both for the informative content and the personal opinions of my professional colleagues around the state. As a senior medical student I have learned a great deal from the *Ohio State Medical Journal* and consider it a valuable asset to my medical education. Upon reading the recent articles concerning the "practice of medicine in the year 2000" and the definition of "quality of care," I am compelled to share with you an opinion that has been growing strongly since the beginning of my medical education and is further strengthened by the numerous recent articles dealing with the changing faces of medical practice.

Perhaps the strongest message I receive from these articles is neither stated nor implied — the future of medical practice is *my* future. New physicians of my generation will likely be most affected by the policy and economic changes in medicine being projected for the years ahead. Although these changes will undoubtedly be dramatic, I firmly believe that two fundamental elements of the practice of medicine shall not be compromised in the name of cost containment and professional review — effective communication and compassion. Physician-patient contact time is being greatly diminished by shortened hospital stays, more outpatient procedures, and brief office visits in settings such as HMOs or PPOs. Even in the face of such time limitations, these basic and essential factors of medical practice must not be sacrificed.

Like most students of a modern medical education, I have received a large portion of my clinical training in the tertiary care setting of a university medical center in which the majority of patients have been referred through a course of several physicians. This setting has been invaluable not only from the clinical aspect but also in learning the therapeutic importance of the patient-physician relationship. I have often witnessed the effect that a few moments of instructive conversation at the patient's educational level and an expression of genuine concern can have on this relationship. In the case of a patient having been properly informed and shown appropriate concern throughout his or her clinical course, the problem at hand can be rapidly identified and the proper diagnostic and therapeutic modalities instituted, thus maintaining the trust and confidence that has been instilled by our preceding colleagues. When, however, these elements have been previously omitted, the atmosphere is often filled with tension and important issues are clouded by feelings of confusion, fear, and alienation. This obviously leads to diminished efficiency in diagnosis and therapy and thus a decreased quality of care.

Medicine is clearly changing and so are the demands placed on its practitioners. Our patients, too, are changing and with recent advances in diagnostic and therapeutic sciences the spectrum of the patient population has been expanded to include those with prosthetic devices, organ transplants and advanced age as well as those with environmental cancers, AIDS, and chronic illnesses which less than a decade ago claimed lives much more rapidly. It is often these patients who have exhausted the support sources of family and friends and are most in need of explanation and empathy. Unfortunately, it is also this segment of the patient population who can easily be lost within their own voluminous medical records. Patients with less dramatic pathology are not exempt from the need for instruction and compassion, for we have all witnessed the mental anguish that can result from chronic diarrhea, incontinence or incurable pain. It seems clear that the patients we treat are not unlike ourselves, sharing the necessity to understand those factors which change our lives and welcoming the support of those around us in times of uncertainty.

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Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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Revised, April 1982. 5685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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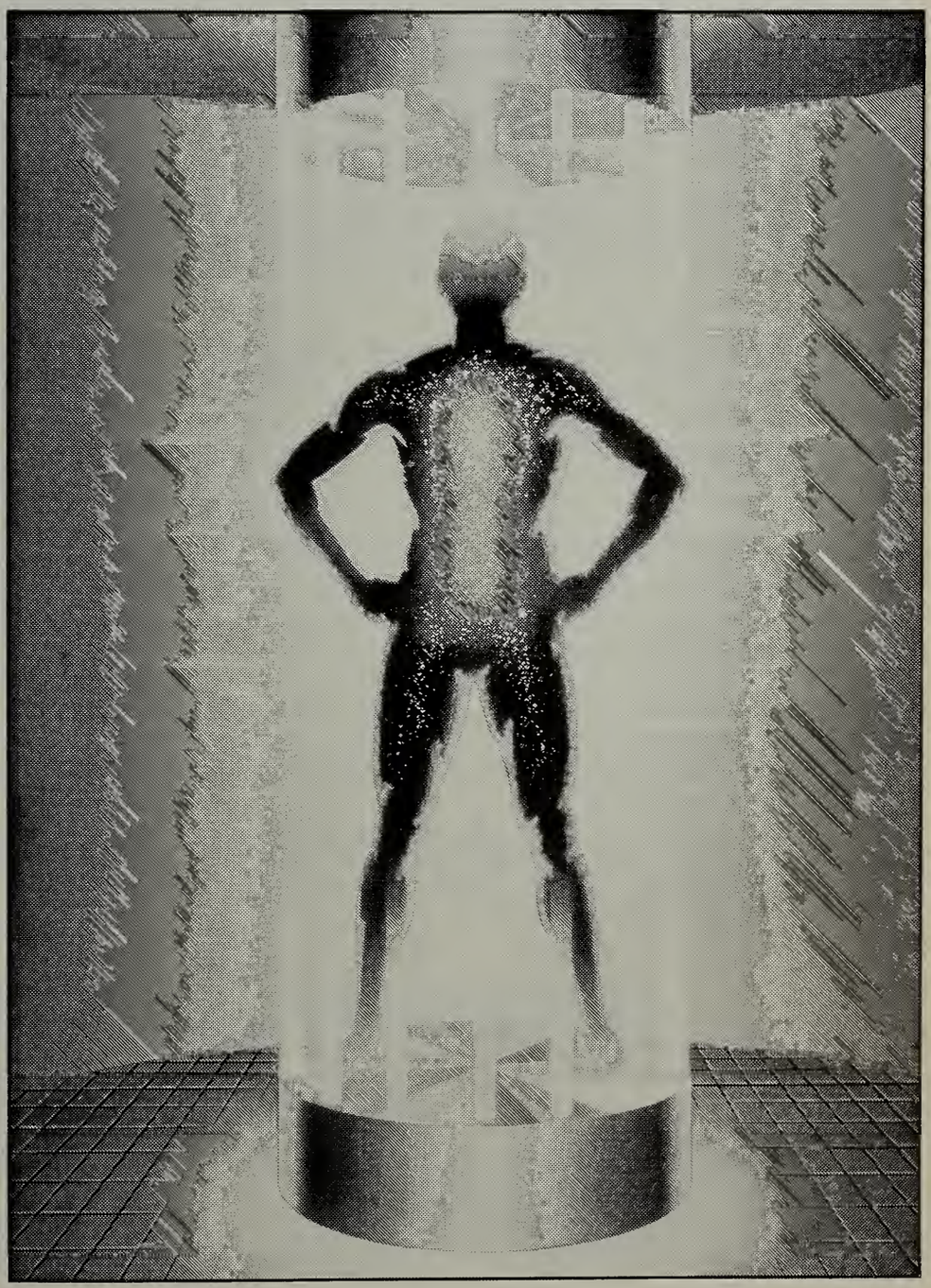
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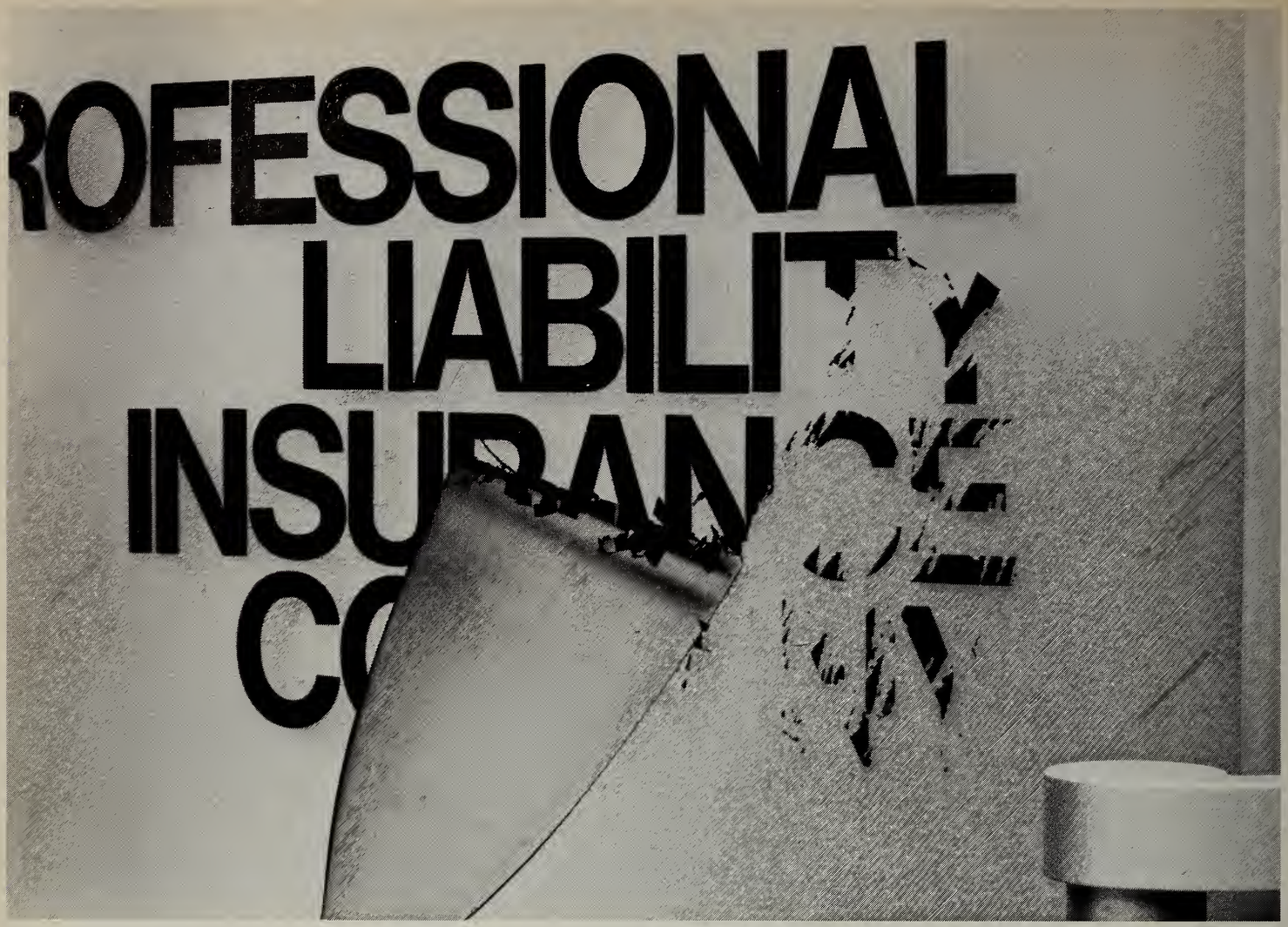
"The future of medical practice is **my** *future. New physicians of my generation will likely be most affected by the policy and economic changes in medicine . . ."*

the future of medical practice and define its quality of care I offer this thought. While the diagnostics, therapeutics, and economics of this profession will always be dynamic, the humanistic needs of its patrons will always endure to winds of change and serve to remind us all of a promise each of us undoubtedly claimed upon entering the practice of medicine, a genuine concern for the well-being of others. To my seniors I express my gratitude for instilling the importance of these fundamentals as part of a complex, data-based medical education. To my student peers I share the experience of taking an active role in patient education and the warmth felt from a patient's handclasp and expression of thanks for showing concern. To all I extend the challenge of executing the promise we have all claimed by protecting the value of effective communication and compassion as we strive together to provide a superior quality of care in our 21st century practice of medicine.

I respectfully request these thoughts be given consideration for mention in your journal. I feel the message is important and may stimulate practitioner and student readers alike.

Michael R. Humphrey
Senior, Ohio State University
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Is The Time Ripe For a Doctor's Union?

By R.V. Gracilla, MD

Once upon a time, there was a King who ruled his kingdom successfully. Everyone was happy, for they received the best there was to offer in everything. The subjects were loyal to him and he likewise reciprocated. In time, he developed a strange compulsion to work harder for his subjects' welfare to the point of exhaustion. The King didn't care what was happening around his kingdom and he fell asleep for 30 years. While the King slept, chaos developed. Everyone wanted to be King. Even the nursemaids exclaimed "The King is dead! Now I can also be King!" Friends and foes organized forces for the revolution and ultimately prepared for the "coup d'etat." He was blamed for every petty adversity they suffered. But King "Rip Van Winkle" woke up. Sure enough, he saw the writing on the wall — he was King no longer . . . Sound familiar? Extrapolate the same scenario in the '80s and it does ring some bells. Webster defines "apathy" as "lack of emotion, lack of interest, indifference, impassiveness, lethargy, unconcern." I confess I've been as guilty as everyone else. As long as the fire is five blocks away, "it ain't gonna burn my house."

Suddenly we find ourselves by cunning regulatory forces, foremost among all, "Big Brother" (Government). Breiner, in an article "American Medicine From Outside Looking In," states the ones responsible for increased government control policies over the physicians are the same people from the outside looking in — academicians and bureaucrats who had never attended medical schools, never practiced medicine, yet have a tremendous impact upon the American health care system. Government officials, educators and workers in private industry are commissioned to design health care policies in America. Ironically, a few physicians and a "growing horde of PhDs" had contributed their talents to the current health care crisis. Perverse philosophies evolved by these same groups of advocates that will eventually destroy the golden tradition of a thousand years of Hippocrates and Maimonides, without the physician's input. Not very long ago, it would be unthinkable to request a nurse for permission to do a cholecystectomy. Thanks to the bureaucrats, it is now a fact of life. Now comes HB 315 Nurse Practitioners Act — a new Pandora's box in the offing.

PPS and DRGs that were astutely implemented in New Jersey on an unsuspecting public are here to stay and predictably will likewise be imposed upon the passive physician, like it or not. Hospitals are struggling to stay afloat and the legal profession is having a "heyday" nurturing the 35,000 new attorneys graduating every year, exploiting the legal traps of DRGs.

HMOs, PPOs and IPAs are current bywords and more new mutants are popping up — PPI (Preferred Provider Insurance) leading to FMP (Family Maintenance Plan) and just one more icing on the cake, HSS (Human Services Supermarket). Discount fee for paper medicine has finally arrived.

Health care business has turned big business overnight. Corporate monsters systematically devour hundreds of hospitals capitalizing on their demise. And what about the physician's role in these

"Physicians are intelligent but super-independent creatures . . . we can't, at times, discern the tree from the forest . . . but I am confident that we'll eventually all stick together . . ."

settings? . . . Just an employee. These corporate structures are reaping huge profits in health care ventures by dubious schemes at the expense of the physician's labors. Yet, if this were turned around, through a physician's concerted plan of action, it is unfairly termed violation of the FTC.

They say competition is healthy in bringing top quality goods to a reasonable price, and accordingly should work in the health care industry. While the transportation, telecommunications and the oil industries, to name a few, are being de-regulated to enhance competition, the health care industry is getting more and more regulated. Dr. Orient of Tucson, Arizona, claims that new regulations breed unhealthy competition.

Let me say that our world here is the envy of millions around the globe. Our health care system is second to none. Unfortunately we're standing and watching it gradually erode, seeking the same level of inferior care in other lands. What went wrong? One reason is apathy. The physicians have lost the control of the direction of medicine.

Physicians are intelligent but super-independent creatures who can't get together or agree on a common issue. I submit that we can't at times discern the tree from the forest. But I am confident that we'll eventually all stick together, otherwise we'll hang separately. The ancient strategy of divide and conquer is still applicable today, and is working against the physicians efficiently. We are so divided and panic-stricken that everyone is running in many directions. In point of fact, we are so scared we are going to be left out, we sign contracts in blind faith.

Therefore, shall we continue to sit idly and accept these current events or unite together to turn the tide? Is it now long overdue for a doctor's union? It is sweeping the West Coast rapidly. Should we have a viable alternative by creating something together, control it, and call it our own? We might as well, rather than work for someone else.

Now that we find ourselves helplessly in the middle of the ocean watching the boats go by, the immediate question that comes to mind is — how long can we tread water?

R.V. Gracilla, MD, is an orthopedic surgeon practicing in Warren, Ohio.

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OSMA NEWS

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Job-related stress — a growing health problem

Work-related neurosis is pushing out other disabling work injuries in job-related insurance claims, says the Atlanta-based National Centers for Disease Control in its weekly report prepared by the National Institute for Occupational Safety and Health.

According to a study released last year by the National Council on Compensation Insurance, claims for the gradual onset of "mental stress" accounted for more than one in every 10 occupational disease and injury claims, and the average cost of those claims was higher than for other work-related health problems.

A similar study in Tennessee, conducted by NIOSH, found that most of these "mental stress" claims are filed more frequently by workers in health care, service jobs and blue-collar factory positions than by workers in any other job.

Conditions such as work overload, lack of control over one's job, non-supportive bosses and colleagues, limited job opportunity, undefined tasks, and rotating work shifts can contribute to a worker's dissatisfaction with his or her job which, in turn, can cause psychological disorders including neuroses and depression, anxiety, irritability, drug abuse, sleep difficulties and physical complaints such as headache and stomachache.

"The problems impose substantial health and financial costs in the United States," says the CDC.

With the problem of job-related psychological disorders so hard to measure, it is also difficult to predict future trends, says Alex Cohen of NIOSH. But there are indications that job-related stress and its accompanying health problems may increase.

"I think we're going to be seeing a shift from occupational safety and health problems in . . . mechanization to more problems of a psychological nature."

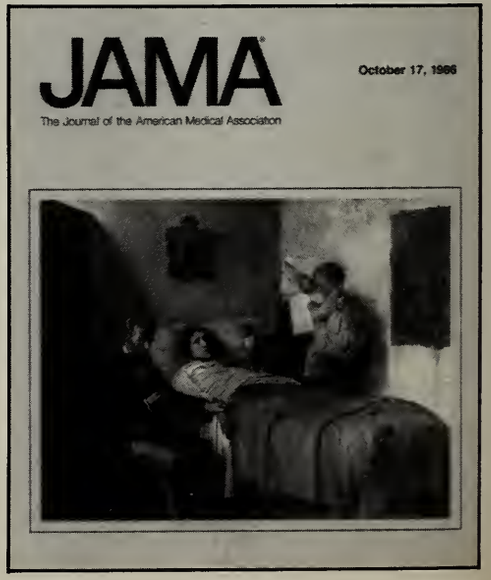
Safer pregnancies for older moms

The maternal mortality rate for women over 35 has fallen by about 50 percent in recent years, according to a study by the Centers for Disease Control in a recent issue of *JAMA*.

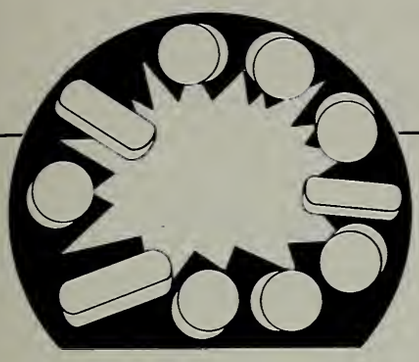
"Although older women will probably continue to be at higher risk of maternal death, recent trends in maternal mortality rates in the U.S. should be reassuring to young women who are considering postponement of pregnancy and to women age 35 or older who are comtemplating pregnancy," the report stated.

In good company

If you've had an article rejected by the *Journal of the American Medical Association* (JAMA), don't feel bad — you're not alone. Last year, *JAMA* received 3,446 manuscripts for consideration. Only 18% were accepted for publication, and only 13% of unsolicited manuscripts were accepted. *JAMA* has a panel of 4,500 peer reviewers from around the country who assist in the selection of new material.



Edited by Deborah Athy



Who's cracking up?

According to survey results of cocaine/crack users who called into a New York cocaine hotline, "The majority of (these) crack users were male (72%), were 20 to 39 years old (94%), earned over $16,000 per year (57%), spent over $100 per week on the drug (75%), and switched to crack after snorting cocaine powder 'occasionally' (81%)."

The researchers, who published these findings in a letter to JAMA, reported that crack is potentially more dangerous and addictive than cocaine and may increase the risks of "acute toxic reactions including brain seizures, cardiac arrhythmia, respiratory paralysis, paranoid psychosis, and pulmonary dysfunction."

Pelvic inflammatory disease cases increase

Approximately one million women in this country can expect to contract a fertility-threatening sexual infection this year, says a new study led by A. Eugene Washington of the National Centers for Disease Control.

"Pelvic inflammatory disease (PID) is one of the most widespread and debilitating diseases affecting women today," says the study, which estimates economic losses from PID and its complications at $2.6 billion in 1984 — a figure that is expected to increase to more than $3.5 billion in 1990.

The disease can lead to chronic pain, infertility or internal scars that can cause a fertilized egg to lodge outside the womb, says Washington. He adds that at least 250,000 of the one million women who get the disease annually will suffer such long-term consequences.

On the job, off the habit

Smoking and working don't mix, according to a recent on-the-job survey reported in AMA News.

Of the 660 employers who responded to the mail poll, 36% reported that they have adopted some type of smoking policy, and another 21% are considering such a policy.

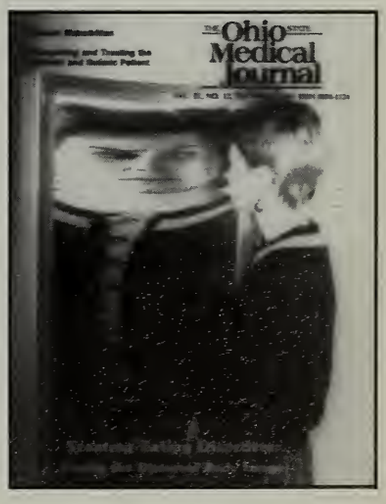
Employers reported no evidence of lower productivity and higher absenteeism among smokers, but chose to enact no-smoking rules to improve overall employee health and comfort, the article stated.

Coffee and heart disease

Those at-risk for heart disease may want to pay heed to a new study which found that persons who drink five or more cups of coffee a day have a three times greater risk of developing heart problems than a person who drinks no coffee at all.

The study, conducted at Johns Hopkins Medical School, was an attempt to test three different theories: one, that coffee drinking in early adulthood is related to heart disease later in life; second, that coffee consumption over a 25-year period had a cumulative effect; and, third, that a possible link between heart disease and coffee, consumed in the years just prior to the occurrence of the disease, may exist.

The main finding of the study, which reviewed the cases of 1,130 male medical students who graduated between 1948 and 1964, was that, compared to a person who drinks no coffee, the person who drinks five or more cups of coffee per day has a 2.8 times greater risk of having heart problems. Even when other risk factors were taken into account — smoking, high blood pressure, cholesterol and age — the study found that there is still a 2.5 times increased risk.



Cause or effect?

According to a recent report in the *Archives of Internal Medicine,* mitral valve prolapse appears to be more common in individuals with anorexia or bulimia.

Of 43 anorexic or bulimic patients hospitalized at the University of Kentucky Medical Center, 10 had mitral valve prolapse, the report stated.

"Abnormalities in neuroregulatory mechanisms may play a role in the clinical manifestations of both mitral valve prolapse syndrome and anorexia nervosa/bulimia," the researchers suggested.

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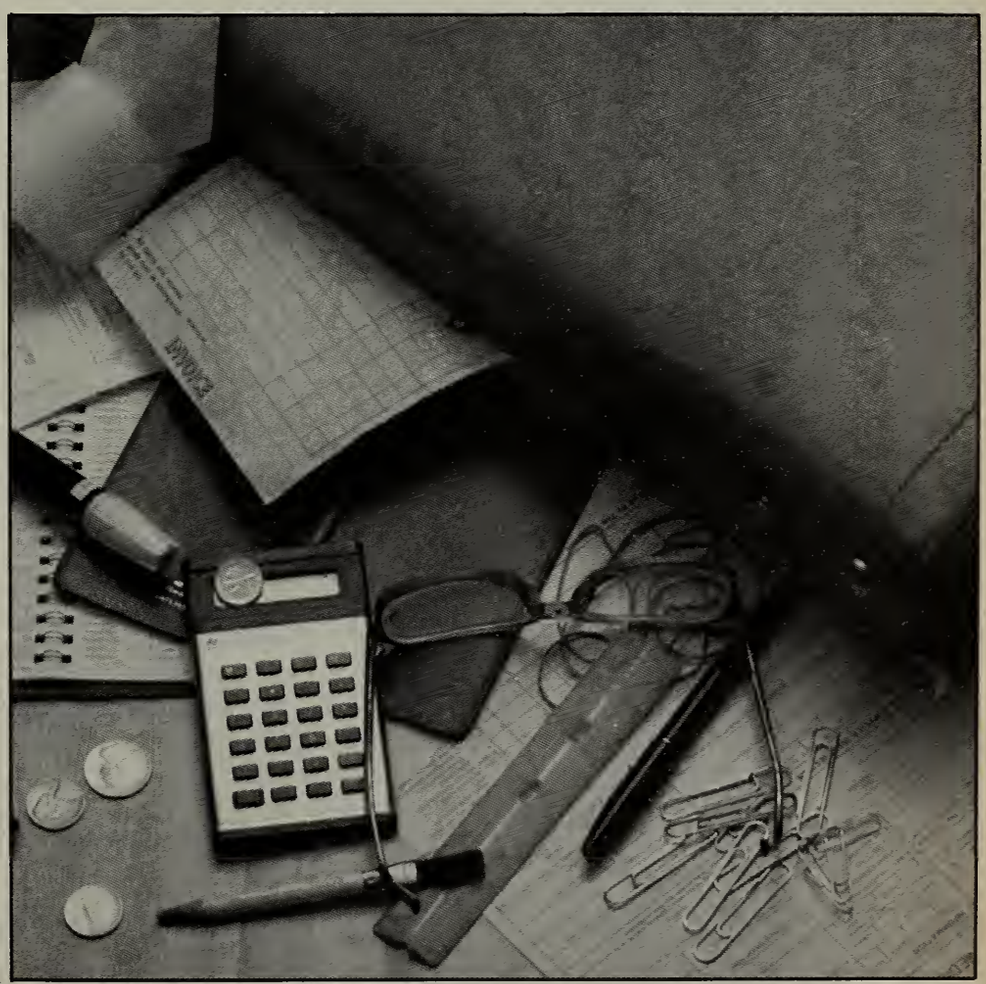
The doctor as businessman . . . AIDS data for Ohio and the U.S. . . . healthy families . . . OPEN doors for the elderly . . . male eating disorders

The doctor as businessman — A contradiction in terms?

The doctor as businessman — where do you draw the line? Readers of the *New England Journal of Medicine* may already know that this subject is of immense personal interest to its editor, Arnold Relman, MD.

Dr. Relman was in Columbus recently to speak at the Fulton Memorial Lecture (for a closer look at this well-known editor and his job, see "So You Want to Edit the New England Journal?" elsewhere in this issue), and he admits that he couldn't resist the opportunity to speak openly on the topic.

"Most of us are so busy with professional duties that we have little time to think about the changes which are influencing our role in medical society," he says. "But the position of the American physician has changed profoundly in recent years. When I started out in medicine 40 years ago, the doctor was the keystone of the system. We practiced independently under a fee-for-service system, and hospitals, clinics and laboratories were there to facilitate the services the doctor provided."



Times have changed the doctor's position substantially, however, he says. In the past five years, especially, medicine has become a business, with physicians either becoming an employee of the system or becoming businesses themselves, bidding for groups of patients at competitive prices. And those who are seeing fewer patients in their offices have begun to look for investments in the health care field to supplement their flagging incomes.

"As a result, physicians are making deals. They are becoming partners in clinics and other health care facilities." And hospitals, in order to attract physicians to their staff and insure their cooperation,

OHIO MEDI-SCENE

The doctor as businessman . . . *continued*

are offering staff members their own deals — usually a share of the hospital's DRG profits, says Dr. Relman.

But lost in all of this negotiating, he says, is a very basic principle.

"Doctors are supposed to be agents for our patients. That's the moral justification for fee-for-service. We're saying to our patients, 'I work for you. You pay my fee, so you're the boss.' "

Yet as patients become packaged in "insurance groups" and contracted for, it becomes harder to establish these "fee-for-service" tenets, he says. As a result, physicians invest in the system. They become agents for the company or the hospital — and the power immediately shifts to these sources.

"The free-market philosophy that works so well for business does not work for health care, because you know and I know the patient is not a free agent. When a patient is sick, he or she is totally dependent on us to make all their important decisions. The patient is not a consumer. He or she is a person who needs the committed trusteeship of a physician," says Dr. Relman.

Society, he continues, has made a contract with the physician. "It subsidizes our education, gives us a licensed monopoly, provides us with power, authority, independence and the enormous privilege of sharing the vital needs of our patients." In exchange, society asks that the physician act with commitment — that he or she place the patient's needs above all else.

The doctor as businessman can't do that, argues Dr. Relman.

"If you're trying to be a purchasing agent for a clinic or a hospital, then you're a double agent," he says, and income, not the patient's welfare, becomes the top priority.

"Society has reached a point where it can admire our technical capacity to prevent disease and improve health, but it's beginning to wonder who we work for and what our priorities are."

It's a legitimate question, says Dr. Relman, "because it's not clear in our own minds what we're supposed to be doing."

Dr. Relman suggests that physicians ask themselves, "Are we technically competent, honest men and women who want to make the best possible living we can?"

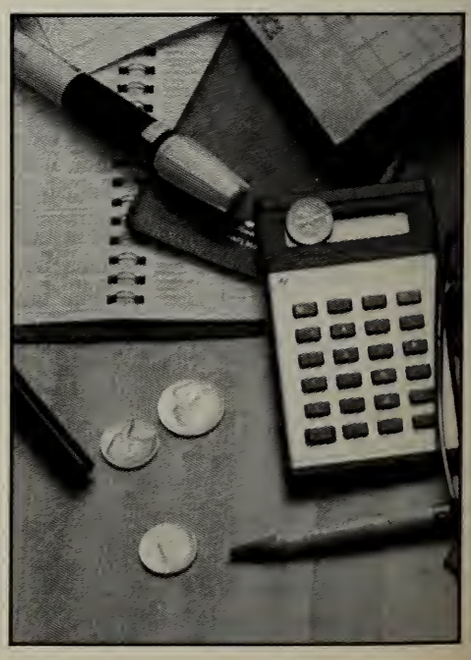
If the answer is yes, he says, "then we are highly skilled businessmen, but we can forget about the practice of medicine, because our freedom and independence will be gone. If the answer is no, then we are not the same as businessmen. Of course we have to be efficient and use our resources effectively — but we have a commitment to do what is right for the patient, and society will support us in this endeavor," he says.

Dr. Relman admits that, in the future, most physicians will probably work for a salary — "but at least let us work as professionals, employed by professionals and reporting to professionals. If we invest in the business of medicine, most of us will be employed by corporations. We'll report to businessmen and be regulated in a way we've never dreamed of" — largely because health care costs will be so high, he says.

"In business," Dr. Relman explains, "it's OK to stimulate consumption to sell your product, but we can't do that with health care. Our job is to distinguish between the superfluous and the necessary — regardless of how that decision affects our income. If the public can't count on us, we will be treated as any other trade group whose prices have risen too high. We will lose our professionalism."

But the die is not yet cast, he assures. Doctors can still turn the situation around and "defend the integrity of our practice."

"We have to make it clear that we work for the patient. If we forget that, we will be in for some very hard times. I hope we don't forget it." — *Karen S. Edwards*



ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) DATA FOR OHIO AND THE UNITED STATES

U.S. DATA THROUGH 7/30/86
OHIO DATA THROUGH 8/18/86

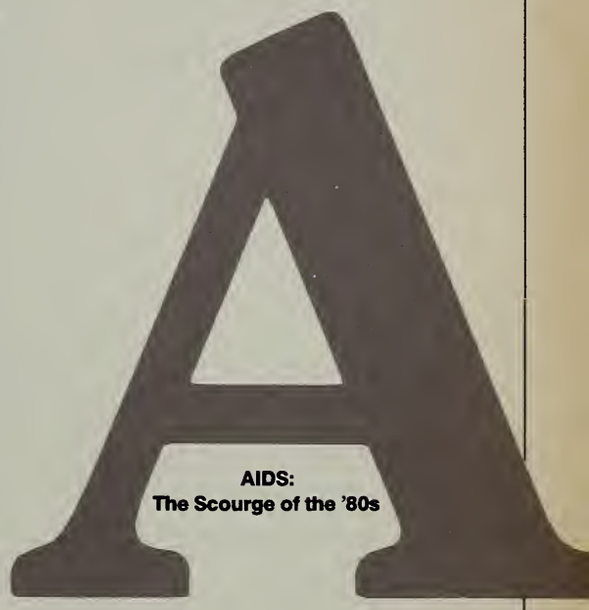
(confirmed cases in Ohio residents)

AGE:	U.S.	(%)	OHIO TOTAL	(%)	OHIO < 1985	OHIO 1985	OHIO 1986
< 13	310	(1)	1	(0)	0	1	0
13-19	95	(0)	2	(1)	1	0	1
20-29	4,641	(21)	52	(24)	21	18	13
30-39	10,394	(47)	94	(43)	32	43	19
40-49	4,597	(21)	44	(20)	19	18	7
50+	2,136	(10)	26	(12)	7	11	8
Unknown	0	(0)	0	(0)	0	0	0
Total	22,173		219		80	91	48

RACE:	U.S.	(%)	OHIO TOTAL	(%)	OHIO < 1985	OHIO 1985	OHIO 1986
White	13,117	(60)	169	(77)	58	70	41
Black	5,404	(25)	47	(21)	22	20	5
Hispanic	3,101	(14)	3	(1)	0	1	2
Other	124	(1)	0	(0)	0	0	0
Unknown	117	(1)	0	(0)	0	0	0

SEX:	U.S.	(%)	OHIO TOTAL	(%)	OHIO < 1985	OHIO 1985	OHIO 1986
Male	20,398	(93)	210	(96)	78	86	46
Female	1,465	(7)	9	(4)	2	5	2
Unknown	0	(0)	0	(0)	0	0	0

OPPORTUNISTIC INFECTIONS	U.S.	(%)	OHIO TOTAL	(%)	OHIO < 1985	OHIO 1985	OHIO 1986
Both KS & PCP	1,208	(5)	14	(6)	9	3	2
KS w/o PCP	3,796	(17)	24	(11)	10	12	2
PCP w/o KS	12,906	(58)	133	(61)	47	53	33
Other	4,263	(19)	41	(19)	13	19	9
Unknown	—	(—)	7	(3)	1	4	2



RESIDENCE BY STATE

1.	New York	7,372
2.	California	5,038
3.	Florida	1,417
4.	New Jersey	1,330
5.	Texas	1,174
6.	Illinois	533
7.	Pennsylvania	511
8.	Massachusetts	439
9.	District of Columbia	397
10.	Georgia	378
19.	Ohio	219
	Total U.S.	22,173

U.S. fatalities
12,186/22,173 .....(55%)
Ohio fatalities
140/219.....(64%)

RISK GROUP:	U.S.	(%)	OHIO TOTAL	(%)	(dead)	(% dead)	OHIO < 1985	(dead)	OHIO 1985	(dead)	OHIO 1986	(dead)
Gay/Bisex	16,044	(73)	182	(83)	(115)	(63)	69	(61)	73	(41)	40	(13)
IV drugs	3,755	(17)	11	(5)	(6)	(55)	3	(2)	7	(4)	1	(0)
Hemophilia	187	(1)	11	(5)	(8)	(73)	5	(5)	3	(1)	3	(2)
Heterosex contact	63	(0)	5	(2)	(5)	(100)	1	(1)	2	(2)	2	(2)
Parents w/Risk	124	(1)	0	(0)	(0)	(—)	0	(0)	0	(0)	0	(0)
Blood Products	230	(1)	3	(1)	(2)	(67)	1	(0)	2	(2)	0	(0)
Gay & Drugs	—	(—)	19	(9)	(9)	(47)	10	(9)	8	(0)	1	(0)
Other	910	(4)	7	(3)	(4)	(57)	1	(1)	4	(2)	2	(1)
Unknown	—	(—)	0	(0)	(0)	(—)	0	(0)	0	(0)	0	(0)

OHIO MEDI-SCENE

OHIO COUNTIES OF RESIDENCE AT DIAGNOSIS

	total	(dead)	< 1985	(dead)	1985	(dead)	1986	(dead)
Allen	2	(2)	1	(1)	1	(1)	0	(0)
Athens	1	(1)	0	(0)	1	(1)	0	(0)
Butler	1	(1)	0	(0)	1	(1)	0	(0)
Clark	7	(5)	4	(3)	2	(2)	1	(0)
Columbiana	1	(1)	1	(1)	0	(0)	0	(0)
Coshocton	1	(0)	0	(0)	1	(0)	0	(0)
Crawford	1	(1)	1	(1)	0	(0)	0	(0)
Cuyahoga	67	(39)	24	(21)	28	(13)	15	(5)
Delaware	1	(1)	0	(0)	1	(1)	0	(0)
Erie	2	(1)	0	(0)	1	(1)	1	(0)
Franklin	38	(24)	12	(11)	17	(9)	9	(4)
Fulton	1	(1)	0	(0)	1	(1)	0	(0)
Gallia	1	(0)	0	(0)	0	(0)	1	(0)
Greene	3	(1)	0	(0)	1	(0)	2	(1)
Hamilton	21	(13)	14	(11)	2	(1)	5	(1)
Jackson	2	(0)	1	(0)	1	(0)	0	(0)
Jefferson	1	(1)	0	(0)	1	(1)	0	(0)
Lake	3	(3)	0	(0)	1	(1)	2	(2)
Licking	3	(3)	1	(1)	2	(2)	0	(0)
Lorain	3	(3)	0	(0)	3	(3)	0	(0)
Lucas	5	(2)	1	(1)	4	(1)	0	(0)
Mahoning	4	(2)	0	(0)	2	(1)	2	(1)
Marion	1	(0)	0	(0)	1	(0)	0	(0)
Medina	1	(0)	0	(0)	0	(0)	1	(0)
Miami	2	(1)	1	(1)	0	(0)	1	(0)
Montgomery	16	(10)	5	(5)	6	(3)	5	(2)
Pickaway	2	(2)	2	(2)	0	(0)	0	(0)
Portage	3	(2)	2	(2)	1	(0)	0	(0)
Preble	1	(1)	0	(0)	1	(1)	0	(0)
Richland	2	(2)	1	(1)	1	(1)	0	(0)
Ross	2	(1)	1	(0)	1	(1)	0	(0)
Sandusky	1	(1)	0	(0)	1	(1)	0	(0)
Stark	9	(7)	5	(5)	2	(1)	2	(1)
Summit	2	(1)	1	(1)	1	(0)	0	(0)
Trumbull	2	(2)	1	(1)	1	(1)	0	(0)
Union	1	(1)	0	(0)	1	(1)	0	(0)
Warren	1	(1)	0	(0)	1	(1)	0	(0)
Washington	1	(1)	1	(1)	0	(0)	0	(0)
Wayne	1	(0)	0	(0)	1	(0)	0	(0)
Wood	2	(2)	0	(0)	1	(1)	1	(1)
Total	219	140	80	70	91	52	48	18
	64% fatal		88% fatal		57% fatal		38% fatal	

ONSET	CASES	FATALS	(% FATAL)	1985 ONSETS BY MONTH		1986 ONSETS BY MONTH	
1981	2	2	(100)	Jan 7	July 11	Jan 9	July 3
1982	6	6	(100)	Feb 2	Aug 6	Feb 12	Aug 0
1983	23	19	(83)	Mar 5	Sept 11	Mar 7	Sept 0
1984	49	43	(88)	Apr 6	Oct 11	Apr 8	Oct 0
1985	91	52	(57)	May 11	Nov 6	May 8	Nov 0
1986	48	18	(38)	June 9	Dec 6	June 1	Dec 0



What makes families healthy?

The contemporary family has undergone radical changes in structure, size and function in recent years, leaving many experts to speculate that this most basic unit in American society is all but dead. Yet despite the declining number of marriage licenses and the sharp increase in the divorce rate, a surprising number of families remain healthy and intact, a Dallas psychiatrist and expert on family health told mental health professionals attending an all-day seminar in Columbus.

"The American family is not without its problems," Jerry M. Lewis, MD, psychiatrist-in-chief at Timberlawn Psychiatric Hospital in Dallas and director of research and training at the Timberlawn Psychiatric Research Foundation, said during "Mental Health '86 — The New Family Challenge." The program on families was sponsored by the Franklin County Mental Health Board last October.

"There are a lot of obvious strains and stresses on the family today," Lewis continued. "Fifty percent of children under 18 are in families where the mother is working outside of the home. A large number are living in single-parent families."

Still, Dr. Lewis continued, "We tend to overlook the fact that there are a large number of families doing well even in these difficult times. Many children are receiving a good introduction into what family life and intimacy are all about. A very high percentage of people are pleased with their own families, personally — even though they are worried about families in general."

Jules Masserman, MD, a past president of the American Psychiatric Association and author of numerous articles and books on psychiatry and health, also addressed the seminar, pointing out that the term "family" can be used in a variety of contexts. "We can talk about the Mafia as a family or we can talk about the family of man," he explained, adding the term comes from a Greek root meaning servants living together in one household. By all definitions, however, the family serves one of three basic needs of all human beings: interdependency, or the need for meaningful social relationships, Dr. Masserman said.

Today's definition of family might even be expanded to include other institutions such as the school, James P. Comer, MD, currently the Maurice Falk Professor of Child Psychiatry at the Yale Child Study Center and associate dean of the Yale Medical School, said in a panel discussion during the seminar. America is no longer a country of closely knit small towns, rural areas and ethnic groups, Dr. Comer pointed out. Frequently, individuals lead very isolated lives, void of relationships with neighbors, co-workers and extended family members.

"The application of science and technology to every aspect of life after World War II has changed the nature of the family, the community and work," Dr. Comer said. "This has been liberating, but a fragmentation — a loss of sense of community — has also resulted," he said.

Thus, the school — which continues to be a stable institution in society — may assume an even greater role in helping children to develop and perform adequately in a complex society, Dr. Comer said. "The school must provide support . . . that sense of belonging."

Many families today even include individuals who are downright hostile with one another. The new extended family, said Dr. Lewis, includes "a lot of exs" — ex-wives, ex-husbands, stepchildren, stepbrothers and sisters. With all of this comes numerous complications and conflicts. And nearly everyone is involved in at least two family structures — the family you are born into and the family you create for yourself as an adult, Dr. Lewis pointed out.

Still, those factors that make up a happy or healthy family have not changed according to Dr. Lewis, who has been researching families and family health for 20 years. Dr. Lewis defines a happy family as one in which both parents and children are provided a stable background or medium for continued psychological growth and development.

"We no longer believe that the personality is fully developed by the age of 7, 8 or 9," he said. "It is now largely believed that human beings continue to grow and develop throughout a lifetime."

Thus dysfunctional families where one spouse dominates in

"The application of science and technology to every aspect of life after World War II has changed the nature of the family . . ."

OHIO MEDI-SCENE

What makes families healthy? . . . *continued*

power and the other is passively submissive are unhealthy for children and parents alike. "These families produce diminished levels of psychologically healthy children," Dr. Lewis said. Offspring seem to have problems particularly with issues of separation and individuation — they often have a difficult time moving out of the home and establishing themselves as adults. "These families are characterized by rigidity — the heavy-handed use of power. There is little closeness or intimacy. Members don't negotiate or share well."

Healthy marriages are the basis for the healthy family — a small social system that teaches socializing, compromising.

In the healthy family, on the other hand, couples do actively negotiate and balance closeness with a sense of independence. Power is distributed evenly among spouses, and parents experience high levels of both closeness and pyschological intimacy. "There is a high level of commitment to the relationship," said Dr. Lewis. "The other spouse is always number-one in terms of closeness" when compared with all other relationships.

These healthy marriages in turn are the basis for the healthy family — a "small social system that teaches the art of socializing, compromising, etc," says Dr. Lewis. Children who come from these families stand a much better chance of going on to produce happy families themselves, although a surprising number of parents in healthy families come from dysfunctional families, Dr. Lewis has found.

In these instances, he said, it is quite possible that "by relating closely and experiencing intimacy, each spouse acts as a therapist for the other."

As in the past, today's family "has at its core a relationship base — relationship systems that nourish and support each family member," Dr. Lewis said. Yet, unfortunately, today's high-tech society seems to value objectivity, distancing and detachment over an individual's capacity for closeness and ability to relate to others. This could be one reason for the family's seeming demise.

"We need to change our educational efforts to give parity to teaching relationship skills" in addition to objectivity and non-relationship skills, Dr. Lewis said. "By teaching relationship skills in some way, we may be preparing people for a life where openness and understanding are used more effectively in problem solving."

The bottom line, said Dr. Comer, is that "children should grow up in healthy families that help them to deal with all of the complexities of this age." — *Susan Porter*

OPEN opens door for elderly

Ohio Project Elderly Needy, the OSMA-sponsored program to identify and provide medical care to needy senior citizens, was launched in two Ohio counties on October 28.

The Montgomery County Medical Society and the Academy of Medicine of Toledo and Lucas County were the first two county medical societies to get the OPEN program underway. In all, 17 county medical societies have indicated an interest in participating and the program is under consideration in many of the remaining county societies.

OPEN was initiated by the OSMA at the suggestion of William J. Marshall, MD, a Dayton cardiologist and Second District Councilor to the OSMA. The program is designed to assist needy elderly people in the state who may not be receiving medical care by referring them to physician volunteers who agree to accept medicare assignment, or, in cases in which the elderly person has no insurance coverage, to provide them with free physician care.

Two categories of elderly are eligible for participation in OPEN:
Category I — Age 65 or older with Medicare coverage, living at or below poverty level.
Category II — Age 65 or older with no health insurance coverage, living at or below poverty level.

Based on recommendations from the Ohio Department of Aging, poverty level has been established as an annual income of no more than $5,360 for a single person and a combined annual income of no more than $7,240 for two persons.

The Ohio Department of Aging estimates that approximately 17,000 Ohio elderly with Medicare coverage presently live at or below the poverty level. An additional 8,000 Ohio elderly live at or below poverty level with no health insurance coverage.

Although OPEN is sponsored by the OSMA, it is designed to be implemented individually in each county by the local county medical society. For this reason, OPEN is flexible enough to be carried out a little differently in each area. However, since identifying those elderly people who qualify for participation in OPEN is vital to the success of the program, counties who participated will usually work in cooperation with a local aging group or the local medical auxiliary for the elderly.

These support groups not only help to get the word out to potential candidates for participation, they also can serve as the organization which registers the participants.

After eligibility is established, the participant is given the names of physicians who have volunteered to take part in the program.

It is Dr. Marshall's goal that, in addition to providing needed medical care, OPEN will also help generate some hard data on the amount of free care that is provided by Ohio physicians each year. For this reason, after treating a patient, physicians participating in OPEN are asked to report on the cost of treatment.

For more information on OPEN, please contact the OSMA.
— *Carol Wright Mullinax*



Posters, like the one above, are being displayed in physicians' offices to publicize the project.

Male eating disorders: the underdiagnosed population

"About the 16th year of his age, fell gradually into a total want of appetite, occasioned by his studying too hard, and the passions of his mind."

Morton, 1694

The above description by a 17th-century physician touches on the "psychological origin" as well as the "formulation of behavior" associated with anorexia, according to Arnold Andersen, MD, director and attending physician of the Eating and Weight Disorders Clinic (The Phipps Clinic) at Baltimore's Johns Hopkins Hospital.

What makes the passage especially interesting from Dr. Andersen's perspective is that the subject of this early description of anorexia is a young male. Speaking recently at the National Conference on Eating Disorders in Columbus, he said, "Morton was right: Males do have eating disorders, and they are a fascinating, relatively underdiagnosed population."

Why underdiagnosed? For one thing, Dr. Andersen, also assistant professor in the Department of Psychology and Behavioral Sciences at Johns Hopkins, says eating disorders — both male and female — went underground in the period from 1870 to 1970. He describes this lapse of time as "a century of neglect in

OHIO MEDI-SCENE

Profiles in brief

The following are behind-the-scene accounts of four males who have been treated for eating disorders at the Phipps Clinic in Baltimore. Arnold Andersen, MD, gave these accounts as part of his presentation at the National Conference on Eating Disorders held recently in Columbus.

Joe, 17, high school junior. At 180 lbs. Joe felt overweight and unattractive. By following an anorexic pattern of restricting food, he lost 51 lbs. He said he thought being thinner would improve his self-confidence, make him attractive to girls and more respected by the members of his baseball team. Joe attended the clinic as an out-patient, slowly built his weight back to normal, and began working on his social skills. While Joe says he sometimes still feels fat, he doesn't feel the same need to restrict his diet.

Sam, 20, college student. Sam weighed 199 lbs. at age 13 and had a history of being teased and criticized about his weight. He had two previous psychiatric admissions before going to Phipps Clinic, and had a brief episode of anorexia in high school. Sam shelled out $100 a day on food, binged and purged, abused alcohol and drugs, and was having depression problems. When he entered treatment he was down to 117 lbs. His treatment consisted of interrupting the binge/purge tendencies and toning down his excessive exercise program. He was treated with anti-depressants for his depression, and he joined a drinking support group.

Jim, 22, health spa manager. Jim had a history of being teased about his weight in high school. He had family problems and difficulty handling stress. Through strenuous exercising and binging and purging, Jim began to lose a good deal of weight. When he came to the clinic, he said his goal had been to be perfectly built for his homosexual lover. During treatment, Jim had to learn how to maintain his weight in a healthy manner, stop the binge/purge episodes and develop a healthy physical fitness program.

Ivan, 30, spa instructor. Ivan was criticized for his obesity when he was growing up. He also had family problems — an abusive father and a mother who was psychologically unstable. In addition, Ivan's family expected him to eat large meat-and-potato meals and still stay thin. Ivan had trouble with mood swings and depression. He had trouble forming relationships and he had a lot of aggression stored inside him. Ivan maintained his weight by binging, but he was still unhappy with his body. Ivan is currently still in treatment. Not only did his binging have to be curtailed, but he also had to be treated psychologically. He is still having trouble in social relations, but now when he is depressed, he no longer thinks his body is bad. He says, "It's not my body; it's also not me. This is an illness; this is not something I've done or deserve."
— *Deborah Athy*

Male eating disorders...

continued

understanding and diagnosing eating disorders."

Outdated criteria used to diagnose anorexia, or what Dr. Andersen refers to as "theoretical, dogmatic bias," also played a part in the underdiagnosis of male eating disorders during this period.

Anorexia was initially dubbed an "hysterical" illness, and because men were not thought capable of being hysterical, they were not considered candidates for anorexia. Additionally, amenorrhea was a condition considered essential for a diagnosis of anorexia nervosa; so, again, males were biologically unable to be considered anorexic.

But the 1970s brought a new wave of eating disorders into sight; at this time, isolated cases of males with eating disorders began to crop up. "The appearance of males with eating disorders began raising fundamental issues in understanding psychological and biological sex parity in our society," says Dr. Andersen, who is on the editorial board of the *International Journal of Eating Disorders.*

The number of males with anorexia or bulimia remains small compared to their female counterparts. In his current environment — a tertiary university setting — Dr. Andersen estimates that for every 10 females who show up at the Phipps Clinic there is only one male.

However, the percentage of male eating disorders is much higher in some male sub-cultures. Male wrestlers, for example, exhibit a high incidence of eating disorders,

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CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. ***Issued 7/86***

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References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983; 106(6):1341-1347.* ***2.*** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984;24(Dec):150-159.* ***3.*** *Johnston DL, Lesaowy R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectaris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.*

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because they often have to lose large amounts of weight to meet wrestling criteria. "After awhile, these attitudes about constantly worrying about food take hold," Dr. Andersen says. Meaning that, the wrestler who begins to restrict his food intake on the advice of his coach could end up with a problem which could last well beyond the wrestling season.

Males who depend on their weight for their livelihood — male jockeys, models — also tend to fall more frequently into the eating disorder trap.

Male homosexuals also make up a significant part of the male eating disorder population, says Dr. Andersen. Some studies indicate that about 25% of males with eating disorders are gay — an estimate he finds pretty reasonable — though he points out that 25% is far from a majority.

There is also a "disproportionate number of male medical students" who comprise an eating disorder category — an area Dr. Andersen hopes to investigate further.

Although there are many exceptions, eating disorders occur more frequently in males who are white, unmarried, in their teens or 20s, and who either have some type of affective disorder or who come from families with affective disorders.

In certain respects, males and females with eating disorders are quite similar. "The starvation state — whether male or female — makes people clones of each other," Dr. Andersen explains. They are listless, antisocial, depressed, preoccupied with food. In addition, their perceptions are often warped: "They see, but they don't see; they see, but they distort."

However, there are some very key differences between males and females who develop eating disorders, he points out. The majority of females with eating disorders are at normal weight, while the males who develop these disorders are approximately 20% above normal weight. "Our socio-cultural norms which emphasize thinness in women" probably trigger the occurrence of eating disorders in so many women. From a very early age women receive behavioral messages about how they should look; in fact, by the fifth grade, most women have already started to become weight conscious, he says. "Most males (with eating disorders) have actual experiences of being overweight, rather than perceived experiences of being overweight," he explains.

That's not to say that men are totally immune from society's messages — messages about the weakling who gets sand kicked in his face at the beach, signifying the desirability of muscles. This, too, from a society obsessed with sports . . . whose ideal masculine shape is represented over and over in art, described in literature, and depicted on the big screen.

Many males with eating disorders seem to be wrestling with more than society's norms and messages. Many have associative pathopsychology, or affective spectre disorder.

In addition, many males with eating disorders seem to be wrestling with more than just society's norms and messages. Many have associative pathopsychology, or affective spectre disorder, Dr. Andersen explains, including problems with alcohol, drugs, their families, antisocial behavior, mood swings, etc.

Consequently, treatment must address not only the nutritional aspect of the disorder, but also the psychological circumstances.

Initial treatment begins by halting the starvation stage, in the case of anorexia, and interrupting the binge-purge episodes for bulimics. Generally, anorexics are treated as in-patients at the clinic, while bulimics are out-patients.

"We have to determine the

Why diet?

"Sometimes you have to ask people very simple questions: 'Why are you doing this?' " says Arnold Andersen, MD, director of Johns Hopkins' Eating and Weight Disorders Clinic in Baltimore.

The following are the most common reasons given by male patients for their eating disorders.

- A history of obesity along with a history of being teased, criticized and picked on by another person. These patients often have sensitive, vulnerable personalities as well.
- A desire to be more attractive to males/females.
- A desire to change a specific body part; especially, change flab to muscle. Males seem to be much less concerned about clothes sizes than women, and are more concerned about the actual shape and definition of their bodies, Dr. Andersen says.
- A wish to enhance self-esteem. An individual often thinks that by being thin he will not only change his own view of himself but other peoples' views as well.
- The attainment of ego ideal — a fantasized idea of how one should look.
- The result of complying with a sports-related diet advised by coach or trying to lose weight gain after sports injury.
- An attempt to avoid a family history of obesity-related illness. Males seem to be much more concerned about this aspect of obesity than females, Dr. Andersen says.
- A reaction to feeling that their lives are out of control. Many patients use anorexia and bulimia as a way to gain partial control over their lives. — *Deborah Athy*

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Male eating disorders . . . *continued*

'central dynamic formulation' early in treatment,'' Dr. Andersen says. "We have to know — and the patient has to know — what every part of the treatment is for and what the goal is.'' This means uncovering what purpose the eating disorder has served in the patient's life and discovering how it can be replaced with something healthier — "something without the price tag of anorexia or bulimia.''

The first three to six months are used to get the patients back on the road to normal weight and normal eating habits. During this time, Dr. Andersen finds it very useful to track the patients' levels of testosterone. "Testosterone is intimately related to weight,'' he says; i.e., when weight drops, this hormone drops. Some patients arrive at the clinic with testosterone levels 98% below normal, he adds.

After this initial treatment period, more emphasis is given to the psychological aspects of the illness — uncovering conflicts, fears, etc.; Dr. Andersen recommends support groups during this period.

Treatment often does not end until some two to three years after the patient's first visit to the clinic. Patients are often very fragmented; they usually have a lot to sort through, and they feel as if they have wasted a lot of time because of their illness. "They have to find meaning out of their suffering and learn from that,'' he says.

"We all have impossible ego ideals: one is the Hulk; one is Miss America. We have to learn to focus our energy on other sources.'' — *Deborah Athy*

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Health fraud —

When Magic Replaces Medicine

By Susan Porter

This year, some 45,000 Ohioans will be given the disturbing and disconcerting news that they have cancer. Nearly 60% of these cancers will be curable, but for the other 40%, even proven medical treatments will not be able to save the patient from the nation's number two killer.

It is little wonder, therefore, that nearly one-third of those who are told they have cancer seek some form of treatment outside the proven methods of radiation therapy, chemotherapy and surgery, says Braxton Tewart, health program director for the Cancer Control Consortium of Ohio. Be it through a zinc-lined pine box designed to absorb "ozone energy" or the controversial drug Laetrile, made from the residue of apricot pits, many of these cancer victims will grasp for a cure outside of traditional medical practices.

For some, these unproven drugs and therapies will do little more than rob them of their last pennies and hopes as they struggle to find a miracle cure. For others, however, legitimate treatments may be refused or postponed until they are too late to be effective.

Thus, the cost of health care quackery goes far beyond the estimated $10 billion consumers spend on fraudulent health care products each year. The real tragedy lies in the thousands of lives that are permanently handicapped or lost because an easy and attractive quack cure was substituted for a legitimate therapy.

And you don't have to have a serious disease like cancer to be a victim of health care quackery. A recent survey shows that almost half of all consumers have at some time purchased fraudulent health care products, says James S. Simmons, director of the Cincinnati District of the U.S. Food and Drug Administration (FDA), who spoke at a recent conference in Columbus on health care fraud in Ohio.

In addition to cancer cure-alls, devices and drugs that relieve arthritis and other chronic diseases, slow or erase the effects of aging, or promote quick and easy weight loss seem to be the most popular foolers, conference speakers related to the all-day seminar. The FDA takes most seriously, however, those fraudulent health care products which may cause actual physical harm to an

Unable to accept the fact that legitimate medicine is not able to find a fast, easy solution . . . they seek out help wherever it can be found.

individual, such as artificial hair implants which can result in serious infections, or exercise gadgets that damage the heart and other organs. It also investigates those cases where the product delays or postpones appropriate medical treatment, Simmons says, along with the "economic cheats," or those cases of fraud "that only hurt in the pocketbook."

Working in cooperation with the FDA is the Federal Trade Commission (FTC), that branch of government which, among other things, monitors fairness in advertising. According to William Jacobs of the FTC, Section 12 of the Federal Trade Commission Act prohibits the use of false advertising regarding foods, drugs, devices or cosmetics.

Among the cases that FTC has recently investigated are a wheat germ oil pill that promised "vigor, endurance and energy"; a dehydrated vegetable capsule that claimed to prevent cancer; a $300 ear mold designed to reduce weight; and a laser face lift; along with a variety of "cures" for baldness, aging and sexual performance problems.

Another place where health care fraud regularly comes to light is the U.S. Postal Service. Postal inspectors are charged not only with searching through the mails for drugs, bombs and pornography, but also for any schemes which aim to defraud the public, according to Timothy J. Mahoney, JD, chief inspector and attorney for the Eastern Region, U.S. Postal Inspection Service.

According to Mahoney, "Criminal mail fraud started in the 1800s with the selling by mail of quack medical cures." Today, 25% of all mail fraud cases revolve around health care, including the mailings of false Medicare and Medicaid claims, false accident reports, false insurance claims, false billings for health care, false fund-raising for medical research, and a variety of mail-order health care products.

The most popular of the latter, says Mahoney, promises easy weight loss, inviting customers to "dream away pounds" by simply taking a pill that will eat away fat while they sleep. Others purportedly combat hair loss, sexual impotence, aging skin, and cancer, while still others claim to bolster muscle development, bust development and energy levels.

Even local health departments run into some cases of quackery and fraud. C. William Keck, MD, Director of Health for the Akron Health Department, has observed that some patients in his area seek treatment from alternative sources — so-called professionals working in the wellness and holistic health movements. These practitioners may go under a variety of titles and frequently get their degrees from mail-order schools in areas such as herbology, cosmetic therapy and molecular nutrition. They sell patients hundreds of dollars worth of vitamins, health foods and other concoctions which do little or no good and in some cases may cause harm.

Yet patients are attracted to them, says Dr. Keck, because "they tend to give people hope where little hope exists." Unable to accept the fact that legitimate medicine is not able to find a fast and easy solution to their problem, they seek out help wherever it can be found, and will even resort to bizarre practices — such as eating diced or raw animal glands — to solve their physical ailments.

Perhaps nowhere do more quack cures abound than in the area of arthritis. Everything from copper bracelets and uranium mittens to snake venom and cod liver oil have been aimed at the over 31 million Americans who suffer from this painful and debilitating disease.

Why is arthritis so susceptible to fraud, quackery and unproven remedies? One reason is that "arthritis is not a single disease but can be any one of 100 different diseases" — most of which have no known cure, says Irving Kushner, MD, professor of medicine at Case Western Reserve University School of Medicine. In addition, this painful inflammation of the joints and other parts of the body tends to come and go. "It will improve or get worse for no apparent reason," Dr. Kushner explains. "So it is quite possible that a therapeutic agent that does no good looks as if it is helping."

Another part of the problem lies with medicine and science, Dr. Kushner admits. "From the viewpoint of scientific investigation, rheumatology is a generation behind most other specialties. Much more emphasis is placed on finding a cure for those diseases that reduce life earlier in life," he says.

Thus, "Medicine has failed to come up with effective treatments for many types of arthritis, even though its effects on peoples' lives can be terrible," says Dr. Kushner. "Many of its victims can't work. The physical pain and emotional impact are extraordinary. Self-image suffers, sexual activity may be affected, and patients will seek help somewhere — anywhere — to find relief."

Similarly, there are few individuals around who have not at least at one time tried a quick and easy approach to weight loss.

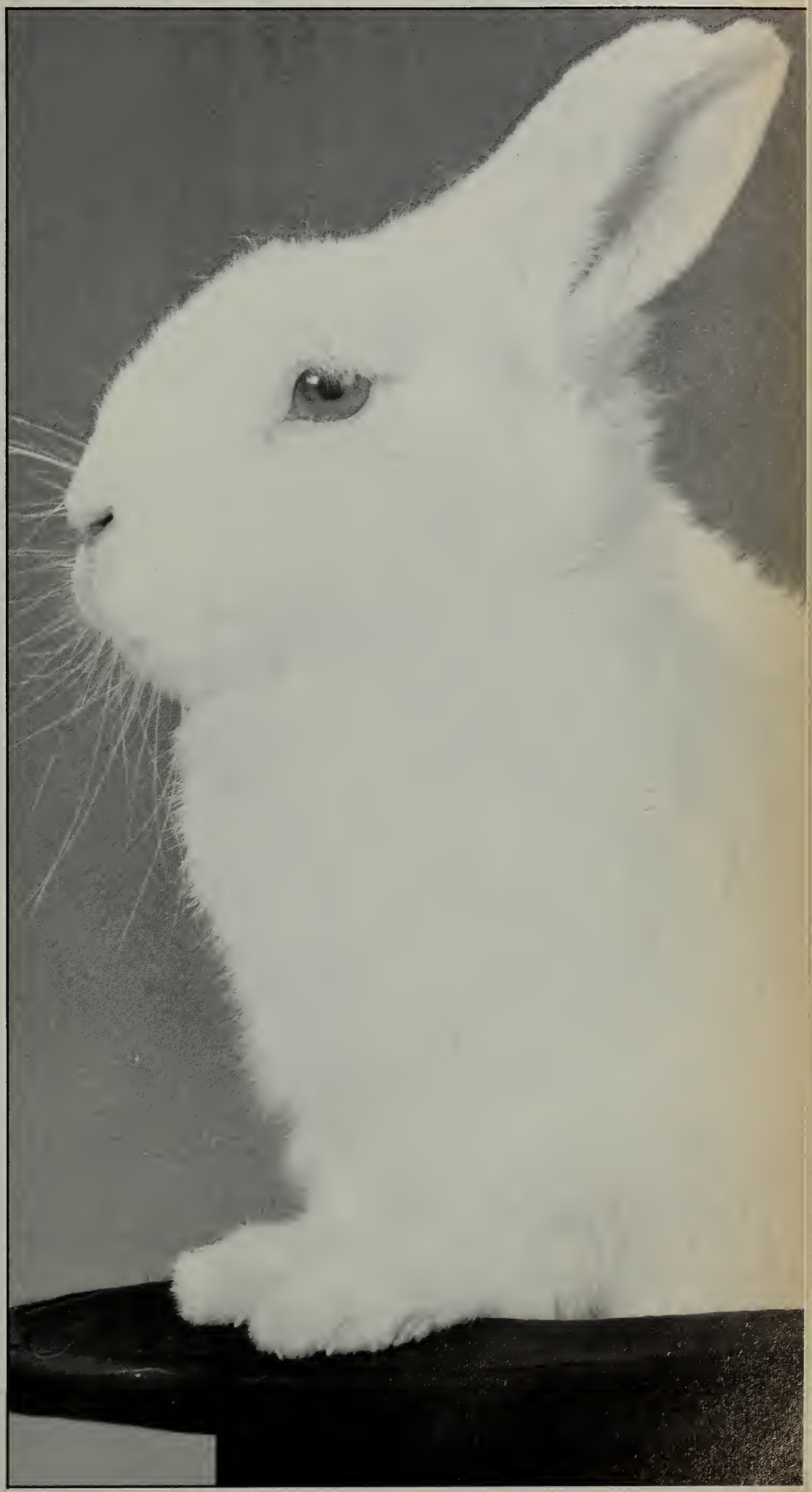
Questionable therapies range from jaw wiring and acupuncture to fad diets and protein supplements, according to Edith Lerner, acting chairman of the Department of Nutrition, School of Medicine, Case Western Reserve University. Most fad dieters experience some initial weight loss due to water and sodium loss, says Lerner. Eventually, however, this weight loss levels out, the diet is discontinued, and the weight is just as easily regained.

In some cases, however, fad diets and nutritional supplements can be dangerous to one's health and may even cause death, Lerner warns, adding there are no substitutes for sound nutritional practices. In addition to electrolyte imbalances, fad diets can lead to sudden death, cardiac arrhythmia and other dangerous conditions.

Also growing in popularity are those drugs or devices that promise "eternal youth" — lotions, potions and creams that erase wrinkles, promote hair growth, hide aging spots, add muscle tone and invigorate the body. Unfortunately, it is the feeble and the vain that are most susceptible to this type of quackery, says Ric Sheffield, section chief, Consumer Frauds and Crimes, Ohio Attorney General's Office. The Ohio Consumer Sales Practice Act is one law designed to protect individuals from these fraudulent products, he says.

Yet it is difficult to protect consumers from themselves — particularly when many are so willing to believe that quack cures are real.

Some even view government's attempts to curb these quacks as conspiracy. "A lot of people mistrust 'the establishment,' " says Dr. Keck, and feel medicine and



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government are out to deny them their chance for a cure, when in fact they are trying to protect them.

Tewart says that the misinformation that surrounds cancer and its cures — both real and quack — are astounding. Many people erroneously believe that all cancers are fatal, he says, when, in fact, the majority of them can be cured. Others put more faith in quack cures. A recent survey at the Cleveland Clinic, for example, showed that 75% of those questioned felt Laetrile was an effective treatment for cancer, and 54% believed cancer could be cured by diet. Another 34.8% believed vitamins could cure cancer, he said.

Another area ripe for health care fraud is cancer prevention, says Tewart. Special diets, pills and even psychological therapies promise a cancer-free existence for those willing to buy into their still unproven theories.

"Unfortunately, a lot of people are not good problem solvers or decision makers where health care is concerned," says Tewart. "People need to learn to make decisions in a more scientific and rational manner," he says, instead of relying on the advice of friends, family and advertisements for their health care needs.

Too often, people realize the mistakes they've made only after they've been taken in. And many are unwilling to report the quacksters and their products because they don't want to take the legal and financial risks that go with confrontation, says Dr. Keck. Also, "They're not always sure where to go with their complaints," he adds.

In addition, many individuals are embarrassed that they were "taken in," and, in most cases, so little money is involved that they are willing to write it off to experience. Some fraudulent companies even offer money-back guarantees on their products, because they know few customers will take advantage of them, says Mahoney.

There are other serious reasons why individuals allow themselves to be taken in by health care fraud, says Thomas J. Halpin, MD, director of the Ohio Department of Health. In fact, many of the changes taking place in the health care system today have opened the door a little wider for quackery and fraud, he says.

The new emphasis on the patient as a consumer — taking more responsibility for his or her own wellness — along with the "tremendous variety of drugs and medical treatments now available" — makes individuals more vulnerable to gadgets and gimmicks that come along.

The public has become very skeptical of authority, says Dr. Halpin. "The consumer movement of the 1960s raised a lot of questions about the world we live in," he says. "This is a positive factor. And yet quacks today are very smart. They hide under the 'little guy' defense and claim that medicine is out against their new treatments." And unfortunately, a lot of people buy their story — and their products.

Most alarming is the fact that there is a growing tendency for people to take the word of a quack over the advice of their own physician. According to Simmons of the FDA, a recent survey of doctors indicated that 32% of physicians believe incidents of health care fraud are increasing due to discussions they've had with their patients. At the same time, 40% feel patients are seeking less information from their physicians, and 50% feel the public is more willing to rely on fraudulent products.

Still, the public must maintain a skeptical eye where health care is concerned and learn to be even more critical of the claims and cures presented on an almost daily basis. "Educating the public may be the best and most effective way to prevent health care rip-offs," says Simmons. "People need to develop a healthy skepticism for those products that sound too good to be true."

Susan Porter is Associate Editor of **The Ohio State Medical Journal.**

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A unique look at editing medicine's most prestigious journal — from the man who should know.

By Karen S. Edwards

Arnold "Bud" Relman, MD, never set out to become an editor.

"I went to medical school to become a doctor," he insists — but a keen interest in the written word and service on numerous editorial boards (including service as editor of the *Journal of Clinical Investigations*) eventually landed him in the top slot on one of the (if not *the*) most prestigious medical journals in the country — the *New England Journal of Medicine.*

Dr. Relman was the featured speaker at this year's Fulton Memorial Lecture, held annually at Riverside Hospital in Columbus, in honor of Richard Fulton, MD, past president of the OSMA who died in 1980. Part of his talk focused on the trials, tribulations and, ultimately, the "privilege" of editing the *New England Journal of Medicine.*

"When the *New England Journal of Medicine* was started in 1812, it was the private property of a group of eminent Boston physicians," he explains. Anything that could conceivably be of interest to physicians of that time period went into the *Journal* — "It wasn't necessarily medical," continues Dr. Relman; so, in addition to the latest medical advances of the day, subscribers could find articles on astronomy, botany — even political tidbits.

The NEJM receives at least 4000 unsolicited contributions from would-be authors each year. Of that total, approximately 10 percent are selected for publication.

Then, nine years later, competition for the *Journal* surfaced by way of the *Medical Intelligencer* — a medical "tabloid" that was printed weekly, as opposed to the *Journal's* quarterly schedule.

The editors of the *Journal* did the only thing they could do," says Dr. Relman. "They bought out their competition" — which explains, he says, why there is still a section in the *NEJM* called "Medical Intelligencer" — and why the publication is published at such frequent intervals.

It is this relentless, unforgiving schedule of the *Journal* which Dr. Relman says is the only unattractive aspect of his job.

"There is never any holiday time or easy time," he comments. Deadlines are always there — and must be met.

"Summer is probably the worst time for us. Our mailbags bulge from manuscripts people have written — then, they go on vacation and forget about it, and our work just begins."

The *NEJM* receives at least 4000 unsolicited contributions from would-be authors each year. Of that total, Dr. Relman estimates that approximately 10 percent are selected for publication.

"Many of them are ruled out right away," he says — and there are several reasons for doing so.

"We never publish anything that has been published anywhere else," Dr. Relman explains, so those articles which have already seen print are rejected out of hand.

"Many are just plain 'nutty,' " he continues, and he admits to feeling a certain sense of responsibility when he receives one of these less-than-lucid manuscripts.

"You worry about that community where this doctor is practicing and actually seeing patients. But what can you do?" he asks.

Following the preliminary review process, Dr. Relman says that the publication is left with approximately 90 percent of the articles which need "to be taken seriously."

This 90 percent is divided according to specialty, then each stack of manuscripts is given to two "referees" in that specialty to review.

"Our computer has referee names for every medical specialty in existence," says Dr. Relman.

If the specialist-referees believe the article is at all promising, it will be brought up for discussion at an editorial board meeting. This process alone weeds out 90 percent of the "serious articles" — leaving 10 percent which are likely to be published.

"I've often envied the editorial board meetings of those earlier days, when the *Journal* was just a quarterly," reflects Dr. Relman.

"The editors would get together over dinner, enjoy some good food, some good wine, and read over the manuscripts. When they had enough material, they put out the publication."

Editorial board meetings these days are far from social occasions, assures Dr. Relman. And even when an article *is* accepted, the editor's job is just beginning.

"Every paper we accept is revised at least once," he says, and every fact in the article will be painstakingly checked and re-checked.

"We can't guarantee that what we publish is the absolute truth," says Dr. Relman — "but it will be the best available information on the subject at that time."

Dr. Relman points out that the belief that "if it's printed in the *Journal,* it must be true" is often a source of trouble for the editors.

"We don't publish on stone," Dr. Relman asserts. "We publish on paper — and paper is biodegradable," he says.

Another problem arises when he or one of the editors solicit an article — and it comes in written in a less than satisfactory style.

"It can be awkward," he admits, "but when we ask for a contribution, we will never promise the author that the article will be published. The material must be judged on its own merit."

Of the 4000 unsolicited manuscripts received each year, approximately 1000 of these deal with the socioeconomic side of medicine — an area which is growing rapidly, says Dr. Relman.

"I've cultivated and encouraged these articles because I believe it's important to provide a forum to express these views."

The *NEJM* is the only national, totally independent forum in which a discussion of health care policies can take place. "*JAMA*, for instance, is the organ of the AMA, and is therefore not free to publish views which are opposite those of the AMA. The same is true of

Though the Journal became the property of the Massachusetts Medical Society, it never became its voice. The Journal remained — and remains today — independent of the medical association.

most of the state medical society publications.''

That the Massachusetts Medical Society can publish such a journal is a fluke.

"In 1921, the *NEJM* — which, at that time, was privately owned — was purchased by the Massachusetts Medical Society for $1.00 — a sum which, according to my information, has never been paid. But even though the *Journal* became the property of the Massachusetts Medical Society — it never became its voice. The *Journal* remained — and remains today — independent of the medical association.''

He likens the society's role to that of the trustees of the Boston Symphony Orchestra.

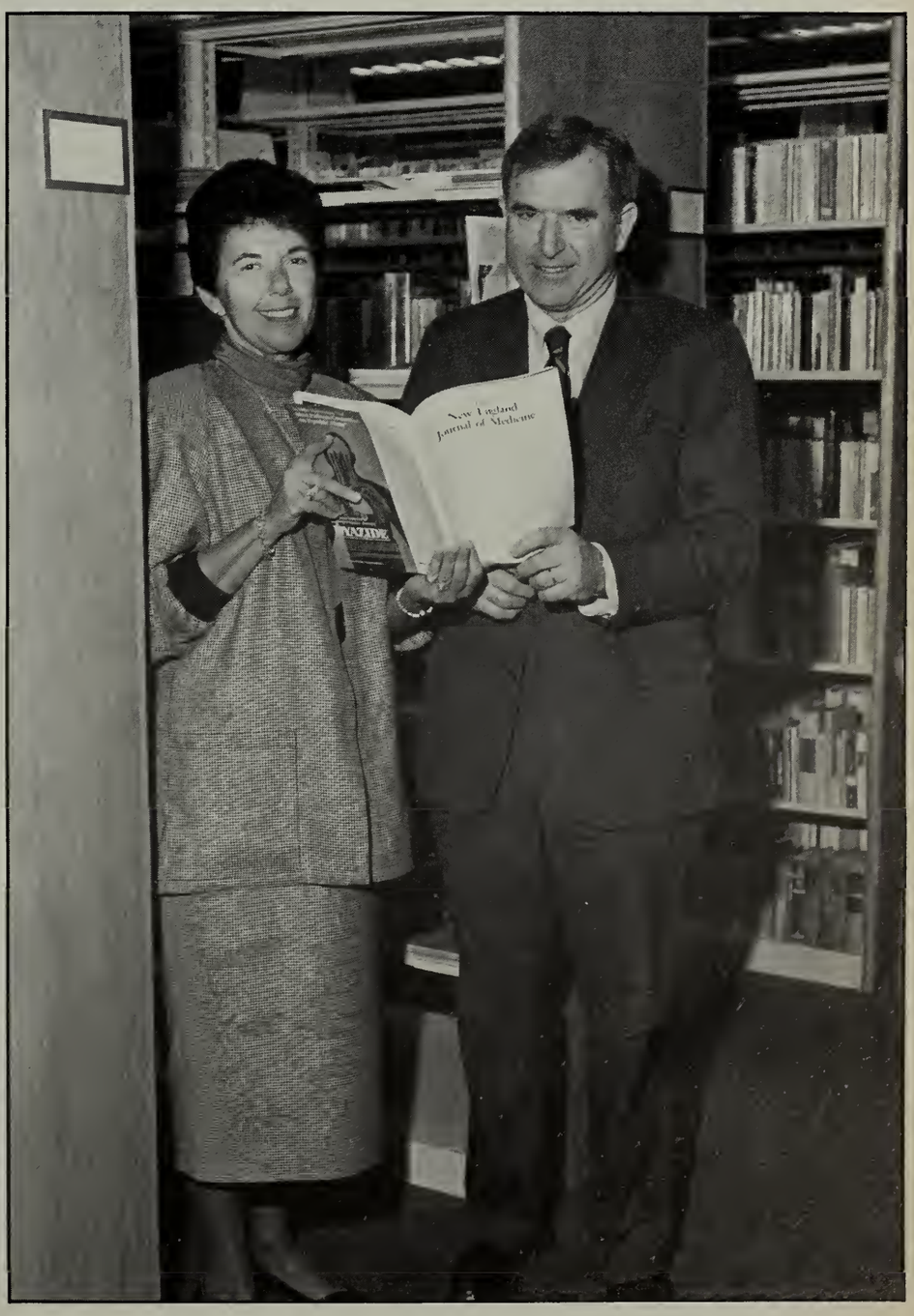
"They can hire and fire the musicians, but they never come to the rehearsals or tell the orchestra what music to play. In the same way, my bosses never tell me what to publish.''

He readily admits that the editors often have their own opinions, and will, occasionally, write editorials.

"But all editorials are signed, and we make it clear this is not the official position of the *Journal*.''

The *Journal* has *no* position, he is quick to emphasize. It is open to everyone's ideas — as long as those ideas are fresh, original, well-expressed, lucid, interesting, temperate, about important issues and supported by accurate data where possible.

"I believe it is important for American physicians to hear all points of view. There are a number



Mrs. Jean Fulton, wife of the late Richard Fulton, MD, looks over the latest copy of the NEJM with its editor Arnold Relman, MD. (Photo courtesy of Riverside Hospital)

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"The Journal can survive without any advertising at all, because of an old Yankee tradition — we don't give it away."

of readers who write in and say they don't want the *Journal* to be a political forum — but if we don't do it, who will? And, more important, how reliable will it be?" he asks.

Despite the letters (some 5000 a year) — both pro and con — Dr. Relman says that the circulation of the *Journal* keeps going up — and is, in fact, the largest, as well as the oldest medical publication in the world — "a fact we enjoy pointing out to our counterparts at the *British Lancet,"* he says with a chuckle.

He also recognizes the tremendous responsibility the *Journal* has assumed as an important source for the media.

"It is not our policy to call attention to anything we publish," says Dr. Relman. "We do not send out press releases."

However, neither can the *Journal* control the press.

"As of 12:01 every Thursday morning, everything we publish is on record. We do allow media contact six hours before publishing — but there is an embargo on the information we publish prior to that Wednesday night release date," says Dr. Relman.

"We are doing the best we can to get the information out to the physician as early as we can, but because of the close media coverage, it's possible that your patients may hear about it first."

One option the subscriber *can* use in the race for information is to subscribe to the *Journal* air mail — an option that's exercised frequently by the media. It does, however, add to the cost of the publication — which by itself isn't cheap.

"The *Journal* can survive without any advertising at all, because of an old Yankee tradition," says Dr. Relman — "We don't give it away."

The hefty subscription fee, however, allows the *Journal* to stand independent. No commercial interest influences what the *Journal* does — and the *Journal* makes no concessions to those commercial interests which advertise.

"We stack the ads front and back, but it doesn't seem to bother the advertisers. We have more business than we can use," says Dr. Relman.

Getting to the "business" of Dr. Relman's talk then — what *does* it take to edit the *New England Journal of Medicine?* What "editorial qualities" should be there?

Well, patience, for one — an attribute Dr. Relman wishes some of his summertime authors could adopt.

"They write their article, then go on vacation. In the meantime, we're trying to work our way through all those manuscripts — and of course if we have any questions we can't reach them," he says. "Then, the authors come back from vacation and wonder why they haven't heard from us yet."

Which is why Dr. Relman also adds a sense of humor to the qualities needed by a *NEJM* editor.

"That — and a tough skin," he says. "If you're thin-skinned at all, you'll never get through those 5000 letters to the editor." **OSMA**

Karen S. Edwards is the Executive Editor of the **Ohio State Medical Journal.**

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The author of *A Christmas Carol* travels through the Buckeye State . . .

Charles Dickens in Ohio

By James G. Ravin, MD

In 1842 29-year-old Charles Dickens was considered the most original and inventive literary genius since Shakespeare. He was even more popular in America than in England. His first book, *Sketches by Boz,* was published in 1836 and became a modest success. It was followed by the overwhelming popular *Posthumous Papers of the Pickwick Club.* Before he was 30, *Oliver Twist, The Old Curiosity Shop,* and *Barnaby Rudge* were published. Americans found his fiction hearty and humane and appreciated his cheerful stories and humor. Americans understood his protest against evil social institutions, and some felt this to be an American victory over the old world.

Dickens had the idea of an American trip in mind for a long time. There was an old tradition of Europeans traveling across the ocean, dating at least as far back as Lafayette. Dickens also wanted to meet fellow literati, such as Washington Irving. Most Englishmen were curious about the new world, and Dickens wanted to see it with his own eyes to record his own impressions.

With his wife and her maid, Dickens sailed across the Atlantic in the winter of 1842. He was received triumphantly. In his own words, "I can give you no conception of my welcome here. There was never a king or emperor upon the earth so cheered and followed by crowds, and entertained in public at splendid balls and dinners."[1]

Even President Tyler granted him a private interview at The White House. The President and the author stared at each other, broke the silence with brief greetings, and the meeting was quickly concluded.

The Far West

After visiting the major cities of the eastern seaboard, from Boston to Richmond, Dickens went westward to Pittsburgh, and then via the Ohio River to Cincinnati and Cairo, Illinois. In England he had invested in a money-losing venture based on the concept that Cairo would become a boom town, but he did not even get off the ship to walk about "the detestable morass called Cairo." Dickens found the Mississippi River "hideous," an "intolerable river," and "slimy" as opposed to the clear Ohio River.[2] He continued on



Portrait of Charles Dickens, by Daniel Maclise, courtesy of the Tate Gallery, London, England

"Cincinnati is only fifty years old, but is a very beautiful city; I think the prettiest place I have seen here, except Boston."

— Charles Dickens

to St. Louis, which he called a "fair" town that was unlikely ever to vie with Cincinnati for "elegance or beauty."[3] Two weeks later he returned to Cincinnati.

Cincinnati

Dickens enjoyed Cincinnati, noting that it "is only fifty years old, but is a very beautiful city; I think the prettiest place I have seen here, except Boston. It has risen out of the forest like an Arabian-night city; is well laid out; ornamental in the suburbs with pretty villas; and above all, for this is a very rare feature in America, has smooth turf-plots and well-kept gardens."[4]

In Cincinnati Dickens was amazed to find that no U.S. currency or U.S. gold coins were available. No American bank notes were honored either. He could not obtain English coins, and found it necessary to use French gold coins. Newspaper advertisements by tradesmen offered sales by barter.

Columbus

The first part of Dickens' trip across Ohio from Cincinnati to Lake Erie was the easiest. The stagecoach ride of 120 miles from Cincinnati to Columbus was on a macadamized road which he termed very good "for an American road."[5] At the brisk rate of six miles per hour, the party made its way there in 23 hours, travelling all night.

Dickens found the terrain beautiful, "richly cultivated, and luxuriant in its promise of an abundant harvest."[6] Except for differences in fences and crops, he felt that it was like travelling in the English county of Kent, one of his favorite areas.

In a column entitled "Strangers," the *Ohio State Journal,* Columbus' daily newspaper, tersely announced "Mr. and Mrs. Charles Dickens arrived in this city today, are at the Neil House. They leave tomorrow, we understand, for Sandusky City, Buffalo, and New York. They have been to St. Louis."[7]

Dickens found Columbus "clean and pretty," and learned that it is "going to be much larger," and as the capital of Ohio, due "some consideration and importance."[8]

That evening in Columbus, the Dickenses held a reception. He found some American customs curious: "The people poured in as they always do: each gentleman with a lady on each arm, exactly like the Chorus to God Save the Queen. I wish you could see them, that you might know what a splendid comparison this is. They wear their clothes, precisely as the chorus people do; and stand — supposing Kate and me to be in the centre of the stage, with our backs to the footlights — just as the company would, on the first night of the season. They shake hands exactly after the manner of the guests at a ball at the Adelphi or the Haymarket; receive any facetiousness on my part, as if there were a stage direction 'all laugh.' "[5]

Upper Sandusky

The following morning the group resumed their journey northward toward Lake Erie. The first 15 hours were spent going 62 miles to the remote outpost of Upper Sandusky. Dickens conveys the difficulty of this:

"It is impossible to convey an adequate idea to you of the kind of road over which we travelled. I can only say that it was, at the best, but a track through the wild forest, and among the swamps, bogs, and morasses of the withered bush. A great portion of it was what is called a 'corduroy road': which is made by throwing round logs or whole trees into a swamp, and leaving them to settle there. Good Heaven! If you only felt one of the least of the jolts with which the coach falls from log to log! It is like nothing but going up a steep flight of stairs in an omnibus."

They stayed overnight in Upper Sandusky in a log-house constructed "with an ingenuity in the art of building" Dickens had never previously encountered. Their room had two doors opposite each other which had no locks or bolts and continually blew open. He desperately tried to block the doors shut with their luggage. Dickens was carrying a large supply of gold with him, and was aware that for a small fraction of that gold, "there are not a few men in the West who would murder their fathers."[9]

Sandusky

The next day was spent travelling for nearly 11 hours from Upper Sandusky to Lower

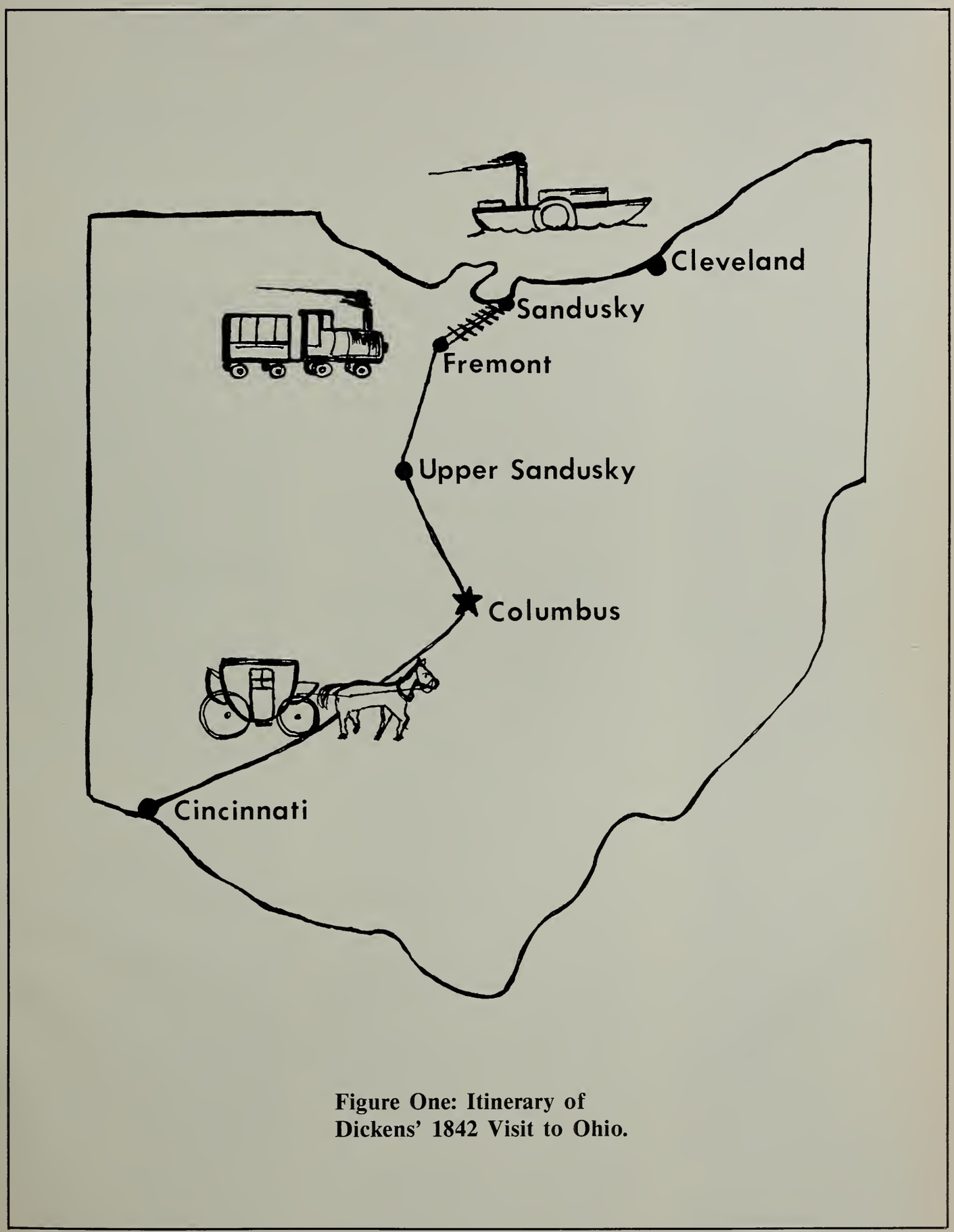


Figure One: Itinerary of Dickens' 1842 Visit to Ohio.

Courtesy of James G. Ravin, MD

"I should think there is not, on the face of the earth, a people so entirely destitute of humour, vivacity or the capacity of enjoyment."

— Charles Dickens

Sandusky (now called Fremont) and Tiffin by stagecoach, then by railroad to Sandusky. Dickens found Sandusky "sluggish and uninteresting . . . like the back of an English watering place out of season."[10]

The Dickenses stayed that evening at a Sandusky hotel run by a remarkable host, best described by Dickens himself: "When I say that he constantly walked in and out of the room with his hat on; and stopped to converse in the same free-and-easy state; and lay down on our sofa, and pulled his newspaper out of his pocket, and read it at his ease; I merely mention these traits as characteristic of the country; not at all as being matter of complaint, or as having been disagreeable to me. I should undoubtedly be offended by such proceedings at home, because there they are not the custom, and where they are not, they would be impertinences; but, in America, the only desire of a good-natured fellow of this kind is to treat his guests hospitably and well." The waitress was equally noteworthy. "When she came to wait upon us at any meal, sat herself down comfortably in the most convenient chair, and, producing a large pin to pick her teeth with, remained performing that ceremony, and steadfastly regarding us meanwhile with much gravity and composure."[11]

Cleveland and its Physician-Mayor

A steamboat took the party from Sandusky to Cleveland the following day. Dickens found the town of 6000 "pretty"[12] and "beautiful."[13]

Dr. Joshua A. Mills, a practicing physician, proprietor of a drugstore on Superior Street, and Cleveland's mayor, paid Dickens a courtesy visit at the harbor. Dickens refused to receive Dr. Mills. He had read an editorial in the *Plain Dealer* while in Sandusky that taunted the British. The editorial had been reprinted from an east coast newspaper, and advocated "war with England to the death, saying that Britain must be whipped again, and promising all true Americans that within the year they should sing "Yankee Doodle" within Hyde Park and "Hail Columbia" in the courts of Westminster." Actually, the editorial was based on certain points of dispute between the U.S. and English governments. After rebuffing Dr. Mills, Dickens noted that "His honor took it very coolly, and retired to the top of the wharf with a big stick and a whittling knife, with which he worked so lustily (staring at the closed door of our cabin all the time) that long before the boat left the big stick was no bigger than a cribbage peg!"[12]

The *Plain Dealer* of April 27, 1842, described Dickens visit to Cleveland further: "The Dickens was to pay here on Monday morning, when Boz was announced to be among us, 'taking notes' we suppose. He came in on the Steamboat Constitution from Sandusky, took a hasty stroll through our streets accompanied by a Boston friend, and returned to his stateroom on board, and shut himself up from the vulgar gaze. His lady, however, showed her plump round English face to as many as wished to look, which quite compensated the gaping crowd, as she and her modest lord are one, according to the English law."[14]

Dickens' Opinions of Ohioans

Dickens did not form high opinions of the people he met in Ohio. In a letter written from Sandusky, he remarked "Their demeanour in these country parts is invariably morose, sullen, clownish, and repulsive. I should think there is not, on the face of the earth, a people so entirely destitute of humour, vivacity, or the capacity of enjoyment. It is most remarkable . . . Lounging listlessly about, idling in bar-rooms; smoking; spitting; and lolling on the pavement in rocking-chairs are the only recreations. I don't think the national shrewdness extends beyond the Yankees; that is, the Eastern men. The rest are heavy, dull, and ignorant."[15]

He did praise some American traits, calling Americans "frank, brave, cordial, hospitable and affectionate."[16] He found Americans full of contradictions. They worshipped the dollar, but educated the people and took care of the poor better than did the English. They admired the shrewd businessman but gave money charitably. They were indifferent to culture, but fiercely proud of Washington Irving and Fenimore

Cooper. They blustered and swaggered, but felt small and sensitive![17]

Public Health Recommendations

During his long visit, Dickens met many American physicians, and visited hospitals, asylums, jails, orphanages, schools and universities. An energetic man who loved to walk for miles at a time, he found the American habit of quickly consuming large amounts of animal food three times daily and rushing back to relative inactivity an unhealthy pattern. He found the people generally unclean and that women dressed inappropriately.

He found rooms overheated in the winter, and recommended opening the windows and exercise instead of the usual practice of huddling about the stove.

His greatest abhorrence was for the American art of expectoration, which he found to be common practice throughout the land: "In the hospitals the students of medicine are requested, by notices upon the wall, to eject their tobacco juice into their boxes provided for that purpose, and not discolor the stairs."[18] He found Washington, D.C., the capital of expectoration: "The Senate is a dignified and decorous body, and its proceedings are conducted with much gravity and order. Both houses are handsomely carpeted; but the state to which these carpets are reduced by the universal disregard of the spittoon with which every honorable member is accommodated, and the extraordinary improvements on the pattern which are squirted and dabbled upon it in every direction, do not admit of being described. I will merely observe, that I strongly recommend all strangers not to look at the floor; and if they happen to drop anything, though it be their purse, not to pick it up with an ungloved hand on any account."[19]

Return to England

After leaving Cleveland, Dickens traveled to Canada, then to New York, and home to England. He composed *American Notes,* a record of his trip, which was published in 1843. He did not return to America until 25 years later, in 1867 and 1868. The second American visit was a speaking tour, a great success in which he triumphantly read sections from his writings in packed halls. He had planned to visit Ohio on this trip, but poor health kept him from visiting our state a second time.

James G. Ravin, MD, an ophthalmologist in Toledo, is past Chairman of the Art and Culture Committee of OSMA and a member of the Program Committee.

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Above: John Buscher, MD, costumed as a surgeon of America's federal period, stands ready to explain his art to visitors attending The Fair at New Boston, near Springfield. Right: A costumed soldier entertains two young camp followers by playing tunes on his fiddle.

Of Medicine and Musters

A Springfield physician plunges into medicine's military past

By Karen S. Edwards ***Photos by Dennis Antle***

When Springfield pathologist John Buscher, MD, enlisted in the army, the first thing he did was hit the history textbooks (specifically the 1776 edition of Dr. John Jones's *Treatment of Wounds and Fractures*). The second thing he did was stitch himself a uniform.

If you're thinking this is *not* your regular army — you're right. This is the First American Regiment, a group which regularly re-enacts the military life (and battles) of 1790 — a time when Ohio was still largely wilderness and not exactly on the best of terms with its resident Indian tribes.

"I've always been fascinated with the history of the American Revolution, and by the French and Indian wars," says Dr. Buscher.

It was this interest that led him, in 1979, to the George Rogers Clark Historical Park, just outside Springfield. There, the First American Regiment — formerly known as the Ninth Virginia Regiment — was re-enacting an historic battle that had occurred on that site.

Dr. Buscher was captivated by the sights and sounds, the action and color. Before he left for home, he found himself signing on as the Regiment's newest recruit.

What followed *that* action, says Dr. Buscher, was research and more research. Textbooks, journals and diaries of that time period were consulted so that he would know everything there was to know about a military soldier of that time period — how he would fight, what he would eat, what he would wear.

"We try to keep everything we do as authentic and accurate as possible," he says. The weapons the Regiment carry, the camping equipment they use, the food they eat are all true to the period. So are the clothes on their back.

"We make our own uniforms," says Dr. Buscher, explaining that patterns are obtained from museums which have authentic versions of the uniform in their collections. Of course, only natural materials are used.

"Generally, the choices are wool and cotton," he adds, "but any material that would have been around in the eighteenth-century can be used."

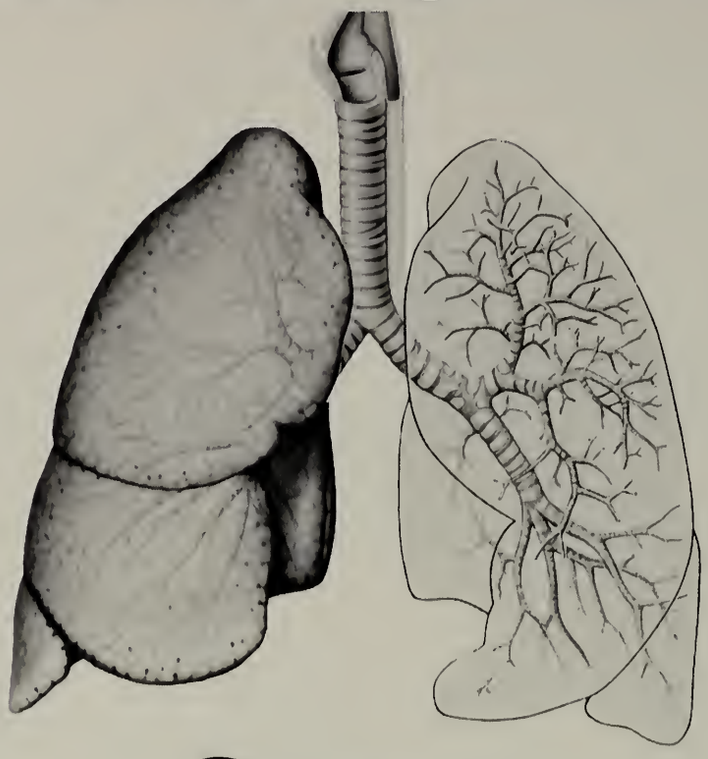
Once Dr. Buscher's uniform was complete, he was able to participate in the Regiment's activities — the drills, battle re-enactments and encampments which occur several times a year, and which have taken him to historic sites all over the country.

It was in 1981, however, that Dr. Buscher's "military" career with the Regiment took on an entirely different twist.

He was camping with the troop at the re-enactment of the Battle of Yorktown in Yorktown, Virginia. The year marked the 200th anniversary of the famous Revolutionary battle, and military re-enactment groups from all over the United States were in attendance. One of these groups had with them their regimental "surgeon," who gave demonstrations of medical techniques of the period, using an array of antique medical instruments.

There was no reason, Dr. Buscher decided, that he couldn't do the same. He came back from

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Costumed visitors stop by Dr. Buscher's tent for a look at his collection of antique medical instruments.

the re-enactment and quickly began his own research into military surgery.

At first, he was disappointed by what he found.

"Washington gave orders that his surgeons were to stay two to three hundred yards behind the battle lines — usually behind a hill," says Dr. Buscher.

But for a man who relishes the role of foot soldier as much as his role as regimental surgeon, the news was less than heartening.

"I like to march and participate in the battles," says Dr. Buscher. Certainly he had not joined this man's army (women did not participate in the armed service at that time) to sit safely behind the battle lines.

Fortunately, further digging soon revealed that there were surgeons of that time period who must have felt the same way that Dr. Buscher did. They would take part in the battles, fight right alongside the troops.

"And that's the kind of surgeon I decided to become," says Dr. Buscher with a laugh.

Since it's difficult for a surgeon of any time period to perform without the necessary tools, Dr. Buscher soon began his own collection of antique medical tools.

"Antique medical instruments are hard to find — not every antique dealer has them," he says. In fact, he has had to find dealers who specialize in collecting antique medical instruments, and now works with several in Chicago, New York and Atlanta.

"What they can't find, I have reproduced by a local blacksmith," Dr. Buscher says.

Now, stopping by his "surgeon's" tent during any of the Regiment's re-enactments or encampments is like taking a step back into medical history. A collection of curved amputation knives and saws are artfully arranged — looking as menacing today as they must have looked to the patients of that pre-anesthesia age. Straight forceps, a cautery iron and jars of powders and potions are close at hand.

The most unusual instrument in Dr. Buscher's collection is an old-time bullet extractor.

"Actually, it works very well," says Dr. Buscher with enthusiasm. "There is one rod with curved prongs which sits inside another rod."

The whole instrument is slipped inside the wound, he explains, and the surgeon arranges it so that the inside rod is placed around the bullet. By lifting up on the inside rod, the curved prongs latch on to the bullet, and neatly extract it from the body.

"The piece is actually later than the period I represent, but I keep it in my collection anyway, since it is still an interesting part of medical history."

The Regiment is careful to post a guard outside his tent when the doctor decides to march with the troops. His colleagues agree that Dr. Buscher's collection is too valuable to take any chances.

But showing off the instruments and explaining how they work is now a large part of Dr. Buscher's role as surgeon — and one he does quite well.

He answers hundreds of questions about "how this was done," "what that was used for," and shocks any number of visitors when he launches into a description of the primitive — and often gruesome — methods used by his 1790 counterparts. Few leave his tent without a silent prayer of thanks for the miracles of modern medicine.

It's a prayer Dr. Buscher can share. For despite the uniforms, the marching, the encampments, and the antique instruments, he is willing to admit that there is nothing quite like the comforting high-tech lab of Springfield's Mercy Medical Center for getting his *own* present-day job done. **OSMA**

Those who may wish to learn more about the First American Regiment — "We're always looking for new recruits," says Dr. Buscher — may wish to contact him or Mr. Floyd Barnum, Director of the George Rogers Clark Heritage Association in Springfield. Mr. Barnum is the man responsible for the activities of the First American Regiment.

Karen S. Edwards is the Executive Editor of the **Ohio State Medical Journal.**

Dennis Antle is a freelance photographer from Columbus.

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The Legal Basis of Malpractice Suits

Part I

By V. Franklin Colón, MD

One of the most distressing things that a physician can encounter during his professional medical career is a subpoena or summons to appear in court to defend himself against a legal charge. Although malpractice litigation is the most common legal action brought against practicing physicians, suits in contract can also be brought against physicians. Although contracts are not the focus of this article, I would like to deal with suits based in contract with a short explanation. Suits in contract originate when a physician fails to produce a promised result. Such suits can be avoided by not promising anything that cannot be delivered. Many states (but not Ohio) require that physicians' promises be in writing before suit can be brought.

The vast majority of suits against physicians are civil actions in tort. Tort law is civil law that deals with the compensation of parties that have suffered loss or injury through noncriminal negligent acts of others. The intent of the law is to compensate the injured parties so that they may be made economically "whole." That means that by providing financial compensation to peoples who have been injured, they are theoretically restored to the status they held prior to the loss of injury. The theoretical intent of the law is victim compensation and not punishment of the party at fault.

American tort law is derived from the English common law. It is continuously being revised and developed. As new technology appears, new theories of tort law are developed to deal with the societal risk/benefit ratios of the technologies. As medical technology has developed, society's expectations for exceptional care have grown. Tort law has progressively imposed greater responsibility on physicians, as well as others using advanced technologies.

When a physician is sued for malpractice, he is alleged to have committed a noncriminal, monetarily compensable error. The allegation is that the physician has not performed up to the *established standards* of the profession, either because of acts of commission or omission. Because of the nature of the profession, physicians are held to particularly high professional standards. Society places high responsibility upon anyone who "holds himself out" as an expert in any given field, but particularly so in the fields of medicine and surgery. In years past physicians were held only to local practice standards, but, as medical education and communication have improved, the standards have become nationwide standards of performance.

To be continued next month

"As medical technology has developed, society's expectations for exceptional care have grown. Tort law has progressively imposed greater responsibility on physicians, as well as others using advanced technologies."

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Popular Nutritional Practices: A Scientific Appraisal

By Jack Yetiv, MD

"You are what you eat." As the baby boomers, former flower children, start to look middle age in the eye, such a "natural" means of self-preservation is quite appealing. The Whole Earth Catalog is long gone; whole grain bread is here as we attempt to eat and exercise our way to quasi-immortality. Nutrition is one of the keywords for health in the '80s. It is being trumpeted by legitimate scientists and quacks alike. Luckily, Jack Yetiv has done us all an enormous favor by writing *Popular Nutritional Practices: A Scientific Appraisal.*

Published this year by Popular Medicine Press, the book runs 318 pages and comes in hardback ($32.95) and paperback ($23.95). The author has a PhD in pharmacology plus his background as a physician to draw upon to provide this up-to-the-minute rundown on current and recent American nutritional practices. The gamut from the lethal liquid protein diet of recent years to the current medical knowledge of high density and low density lipoproteins is presented. It is aimed at a combined audience of the interested lay person, active practitioner, and eager medical student.

Dr. Yetiv is especially talented in presenting complex concepts in a short, clear and fascinating style — leaving the subject quickly before it becomes a chore sorting out the scientific aspects. Copious current references are given of a broad scope. In case the reader misses the point, the author provides "the bottom line" at the end of each chapter.

Illustrations consist primarily of graphs and tables which are often derived from other sources. They are at times not readily decipherable and not attractive. There are no pictures or photographs. Dr. Yetiv may have done better with more pictorial enhancement of the text. The text and layout, however, are quite clear.

Dr. Yetiv does devote an inordinant amount of time (an entire chapter) to tearing down the Pearson and Shaw book *Life Extension: A Practical Scientific Approach.* The premise of this book is that megadoses of various nutritional supplements can prevent or delay the onset of such disorders as cancer and heart disease. He does a good job of critiquing the book but the time he takes is excessive; the reader quickly says to himself "enough already."

"Dr. Yetiv is especially talented in presenting complex concepts in a short, clear and fascinating style — leaving the subject quickly before it becomes a chore . . ."

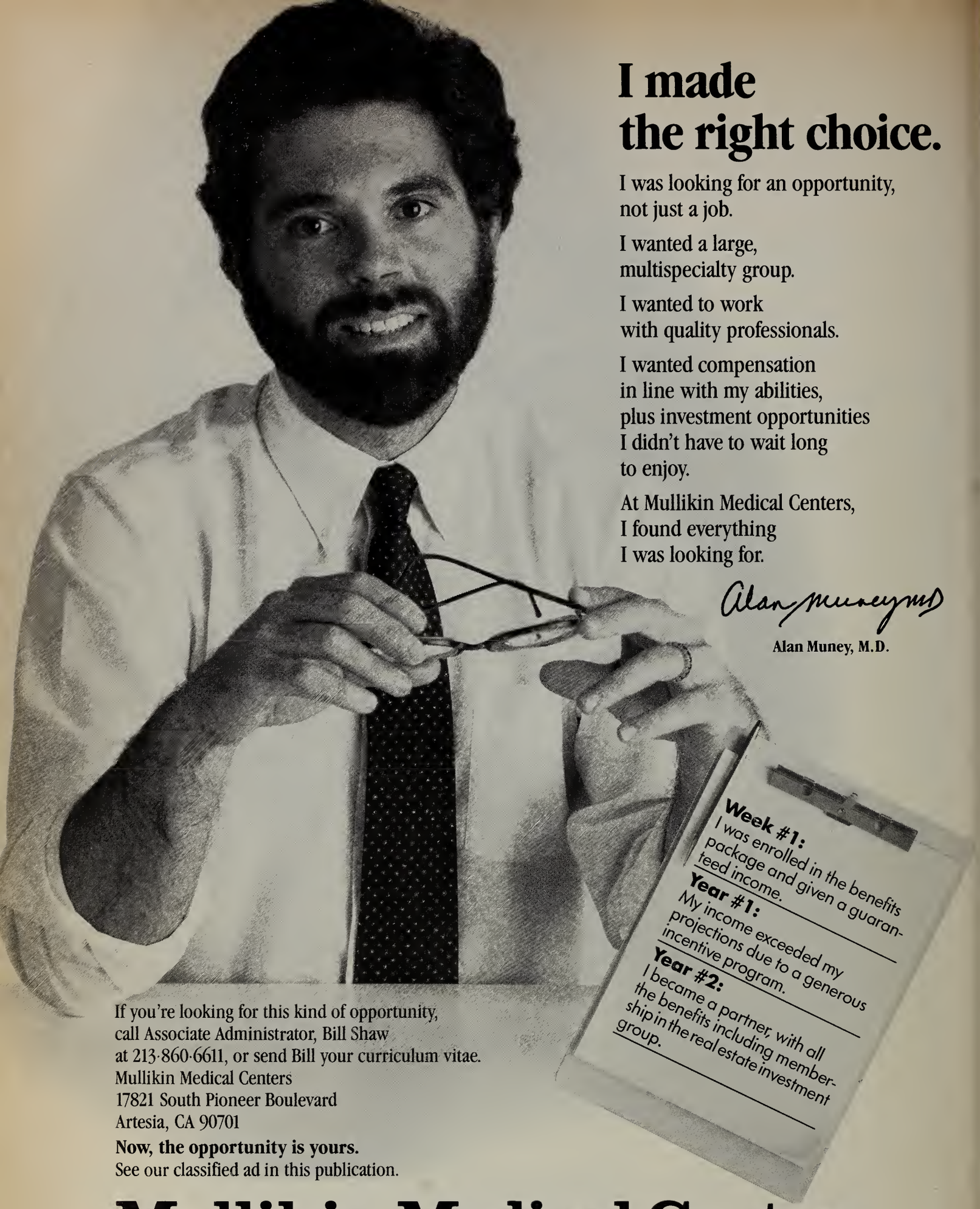
Other topics included in *Popular Nutritional Practices* are fiber, high blood pressure, megavitamins, hypoglycemia, homeopathy and obesity. The chapter on cholesterol, truly a confusing subject, is worth the price of the book.

This book is a must for those with an interest in nutrition — and who isn't right now? Obesity is the number one nutritional disorder in the U.S. The popular press and television assault us daily with new ideas in nutrition. American physicians have been caught with a gap in their knowledge and are just beginning to correct this. Even now medical schools offer little in the way of formal training. Physicians need to compensate for this and this book is a good starting place. I found myself giving it to my patients to read sections that pertained to their situations before I even completed the book. Christmas is coming and I heartily recommend this book for both doctor and patient.
— *Diane Helentjaris, MD*

Diane Helentjaris, MD, family practitioner, St. Paris, Ohio.

Dickens in Ohio . . . *cont.*

3. Dickens, p. 254.
4. Forster J. *The Life of Charles Dickens.* London: Cecil Palmer, 1928, pp. 257-258.
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11. Dickens, pp. 286-287.
12. Forster, p. 269.
13. Dickens, p. 288.
14. Peeke, p. 81.
15. Forster, p. 268.
16. Dickens, p. 242.
17. Johnson, p. 445.
18. Dickens, p. 163.
19. Dickens, pp. 176-177.



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OBITUARIES

DONALD HALL BAKER, MD, Kent; Case Western Reserve University School of Medicine, 1926; age 88; died September 14, 1986; member OSMA and AMA.

JOHN C. BRINER, MD, West Lafayette; University of Tennessee Center for Health Sciences, Memphis, Tennessee, 1930; age 85; died July 4, 1986; member OSMA and AMA.

RAYMOND N. CATOLINE, MD, Youngstown; Northwestern University Medical School, Chicago, Illinois, 1950; age 64; died October 1, 1986; member OSMA and AMA.

NATHAN CHANG, MD, Windham; W. China Union University College of Medicine, Chengtu, Szechuan China, 1945; age 66; died July 15, 1986; member OSMA and AMA.

DAVID A. CONANT, MD, Madison; University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania, 1960; age 56; died September 18, 1986; past member OSMA and AMA.

JOSEPH EDELSTEIN, MD, Mansfield; St. Louis University School of Medicine, St. Louis, Missouri, 1935; age 75; died September 19, 1986; member OSMA.

VICTOR A. FRAME, MD, Cincinnati; University of Cincinnati College of Medicine, 1943; age 70; died August 27, 1986; member OSMA and AMA.

JUAN GONZALEZ, MD, Canton; Facultad de Medicina de la Universidad Autonoma de Guadalajara, Guadalajara, Jalisco, Mexico, 1954; age 59; died September 14, 1986; member OSMA and AMA.

MYRON G. HILL, MD, Cleveland; Case Western Reserve University School of Medicine, 1928; age 85; died September 9, 1986; member OSMA and AMA.

ALFRED HUMPHRIES, MD, Chagrin Falls; New York University School of Medicine, New York, New York, 1943; age 67; died September 17, 1986; member OSMA and AMA.

FLEX founder dies

Frederick T. Merchant, MD, of Marion, died October 25, 1986. He was 75 years old.

Dr. Merchant had been a member of the Ohio State Medical Board from August, 1957 to June, 1971. During his tenure with the Board, Dr. Merchant was active in the Federation of State Medical Boards, and was one of the founders of the FLEX (Federation Licensing Examination) Board. The FLEX examination, under Dr. Merchant's leadership, was to become one of the two pathways to medical licensure used nationwide. Dr. Merchant's involvement on the FLEX board gave Ohio the prestige of being at the forefront in developing requirements for medical licensure in the United States.

Dr. Merchant served as President of the Ohio Medical Board during the years 1963 and 1969; as Director of the Federation of State Medical Boards from 1966-1971; as President of the Federation of State Medical Boards for the year 1970; as General Chairman of the FLEX Board from 1968 to 1978; and as Secretary of the FLEX Board until his retirement in May of this year.

Dr. Merchant was awarded a number of honors by the Federation of State Medical Boards, including a citation for distinguished service to the Federation for two decades, a plaque of appreciation for service on the FLEX Board, and, most recently, the Federation's First Annual Distinguished Service Award in 1986.

ROSCOE J. KENNEDY, MD, Cleveland; University of Iowa College of Medicine, Iowa City, Iowa, 1931; age 82; died October 3, 1986; member OSMA and AMA.

JOSEPH MENDELSON, MD, San Antonio, Texas; Temple University School of Medicine, Philadelphia, Pennsylvania, 1915; age 95; died September 29, 1986; member OSMA and AMA.

DONALD A. MILLER, MD, Warren; Case Western Reserve University School of Medicine, 1937; age 74; died July 17, 1986; member OSMA and AMA.

PHILIP SMITH, MD, Marion; Northwestern University Medical School, Chicago, Illinois, 1943; age 67; died September 10, 1986; member OSMA.

DUDLEY M. STEWART, MD, New Orleans, Louisiana; Tulane University School of Medicine, New Orleans, Louisiana, 1927; age 84; died August 30, 1986; member OSMA and AMA.

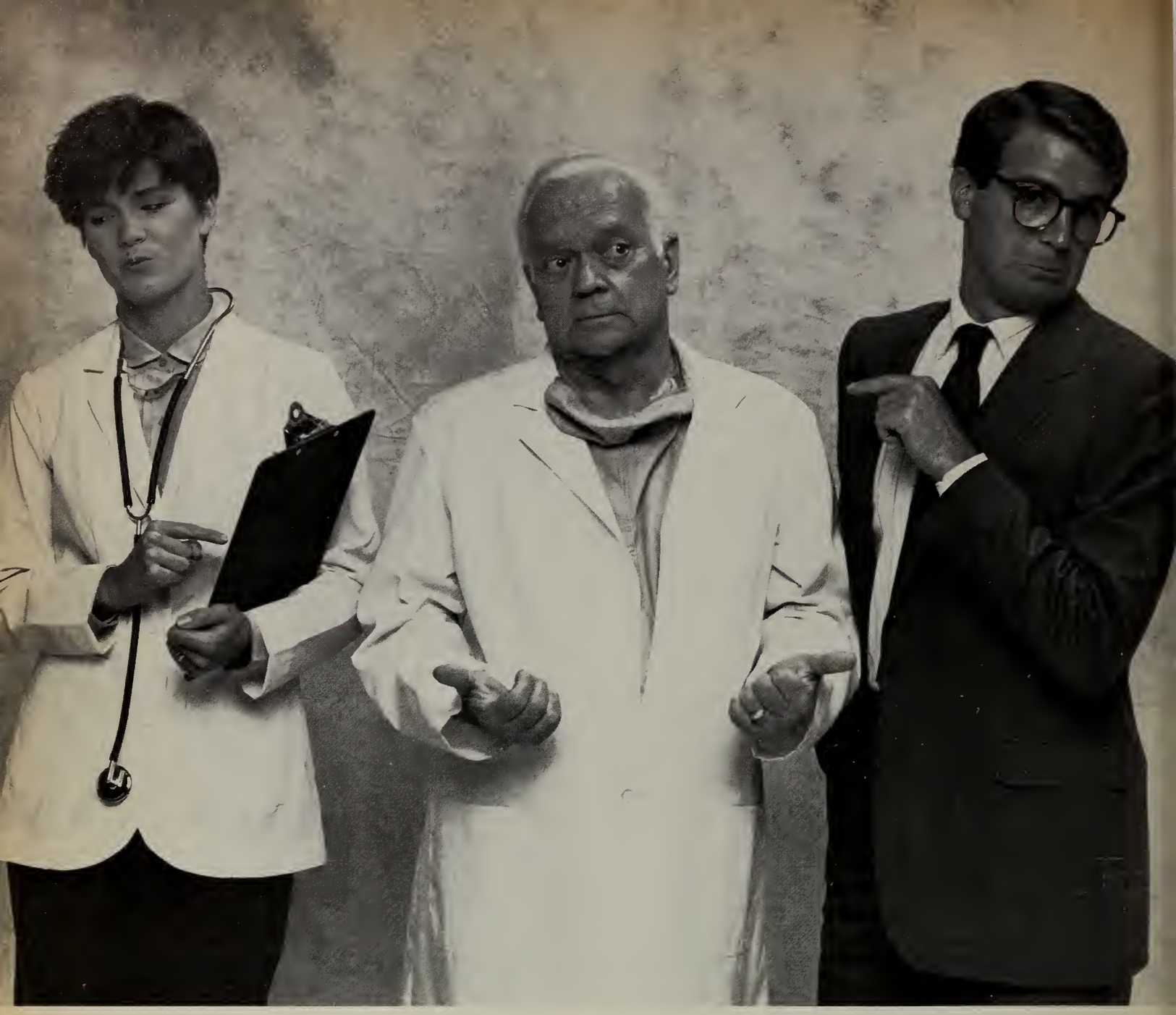
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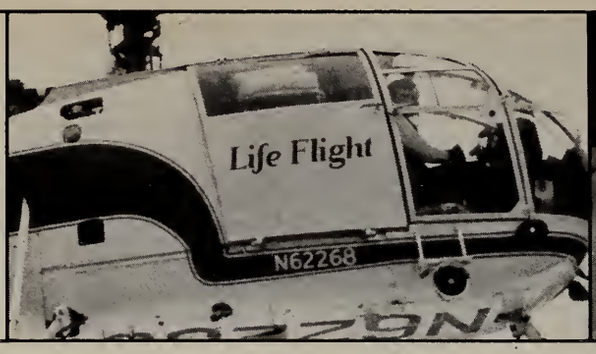
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ELEVENTH ANNUAL MIDWINTER FAMILY PRACTICE: February 1-6, 1987; Hilton Shanty Creek, Bellaire, Michigan; sponsor: The University of Michigan Med. School, Office of Cont. Med. Education; 21.5 AAFP credit hours; fee: $315, $245 physicians-in-training; contact: Gayle Fox, Office of Continuing Medical Education, The University of Michigan Medical School Towsley Center, Box 0201, Ann Arbor, Michigan 48109-0201, phone: 313/763-1400.

FUNDAMENTALS OF OTOLARYNGOLOGY — A CONCISE BOARD AND RECERTIFICATION REVIEW COURSE: January 4-9, 1987; University of Cincinnati Medical Center; sponsor: Dept. of Otolaryngology; 55 credit hours; fee: $575, $450 for residents; contact: Robbie Cornelison, U.C. Med. Ctr., Dept. of Oto. and Max. Surg., M.L. #528, Cincinnati 45267, phone: 513/872-4155 or 872-5460.

EARLY MANAGEMENT OF TRAUMA: January 18, 1987; Lutheran Medical Center, Cleveland; sponsor: Lutheran Medical Center Foundation; 5.5 credit hours; fee: $25, no fee for residents; contact: Jeanette Gaul, 2609 Franklin Blvd., Cleveland 44113, phone: 216/363-2173.

COLUMBUS CANCER CONFERENCE ON LUNG CANCER: March 6, 1987; Hyatt on Capital Square, Columbus; sponsor: Riverside Regional Cancer Institute; 5.5 credit hours; fee: $75, $40 for residents; contact: Angie Leonard, Riverside Medical Building, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-4474.

CONTEMPORARY CONCEPTS IN OTOLARYNGOLOGY: May 2-9, 1987; Caneel Bay Resort, St. John, U.S. Virgin Islands; sponsor: The Communicative Disorders Foundation, University of Cincinnati Medical Center; 30 credit hours; fee: $575, $350 for physicians-in-training; contact: Robbie Cornelison, Department of Otolaryngology and Maxillofac, U.S. Med. Ctr., M.L. #528, Cincinnati 45267, phone: 513/872-4155 or 872-5460.

We're Looking for Contributors . . .

This year, why not become a contributor as well as a reader of The Ohio State Medical Journal? We can always use "Second Opinions," "Essays" and "Letters to the Editor."

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WHY AMA?

The AMA has taken an important initiative in combating prescription drug abuse. An informal steering committee organized by the AMA has developed a data analysis system that would help states detect sources of prescription drug diversion. Cracking down on prescription drug abuse: it's one more good reason why you should be part of the AMA.

To Join,
Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
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Employment Opportunities

Classified advertising rates are $1.50 per word; $1.75 per word if the ad runs in a box.

ATTENTION!

Beginning January 1, 1987, the classified advertising section of the Ohio State Medical Journal will be open to physician-members only. Any OSMA physician who wishes to place a classified ad may do so. Non-physician and non-physician members may purchase a display ad in the Journal.

BE/BC INTERNIST to join five member IM/Subspecialty group in central Ohio with 300 bed hospital and large referral area. Excellent salary and benefits package. Potential full partnership. Send CV to Box No. 116, c/o Ohio State Medical Journal, 600 S. High St., Columbus, OH 43215.

FAMILY PRACTITIONER/ INTERNIST

180-bed progressive community hospital in Cleveland suburbs is seeking BC/BE physician, licensed to practice in Ohio. Guaranteed gross income $100,000+ first year. Excellent medical/surgical facilities and nursing staff, full specialty backup. Send CV to: PO Box 118, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, OH 43215.

Associate Medical Director

Opportunity for an experienced physician in occupational medicine to join our Corporate Occupational Health Division in Cleveland, Ohio. This position offers a unique blend of responsibilities: *corporate occupational health policies and programs, clinical and direct patient care, and research.*

We are seeking a physician, with 3 years occupational medicine experience, who is Board certified. Board certification in Internal Medicine and a strong clinical background desirable.

We offer a highly competitive compensation and benefits program including an excellent relocation plan. Interested candidates should send their CV and salary requirements to: Ms. Jean D. Heflich, Sr. Executive Recruiter; **THE STANDARD OIL COMPANY;** P.O. Box 94694; Cleveland, OH 44101-4694.

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STANDARD OIL
The original Standard Oil Company was founded in Cleveland, Ohio, in 1870.

FAMILY PRACTICE

Boarded or Board Eligible family practitioners are needed to meet our patient population growth in 1987. Our multi-specialty group practice offers an excellent salary and fringe package and a good group of residency trained, boarded Family Practitioners with whom to work. C.V.s to Search Committee, Group Health Associates, 2915 Clifton Avenue, Cincinnati, Ohio 45220.

GENERAL PRACTITIONER or Internist for medical clinic in northeast Ohio. Full-time position. Reply with CV to Box 111, 600 South High St., Columbus, Ohio 43206.

IMMEDIATE POSITION AVAILABLE — Multi-specialty Northeastern Ohio Group seeking BC/BE primary care physicians: Family Practice, Internal Medicine, Pediatrics and OB/GYN. Guaranteed salary with opportunity for ownership. Excellent benefits. Reply Box 115, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, OH 43215.

INTERNAL MEDICINE. ABIM internist seeks same to join his busy solo practice in southeastern Ohio. Must have recent experience in critical care procedures and enjoy primary care Internal Medicine. Nice family town. Send CV, c/o Ohio State Medical Journal, 600 S. High Street, Box 113, Columbus, OH 43215.

INTERNAL MEDICINE

Our multi-specialty group practice continues to grow. We need Board Certified/ Board Eligible internists to meet the needs of our increasing patient population. Both our compensation package and practice environment are attractive. Positions are available in January and July of 1987. Send your C.V. to Search Committee, Group Health Associates, 2915 Clifton Avenue, Cincinnati, Ohio 45220.

LONG-STANDING, ESTABLISHED FAMILY PRACTICE Residency Program seeks an Associate Director. Primary responsibility is undergraduate teaching with additional responsibilities for resident teaching and clinical practice. University associated program in Northeast-

ern Ohio. Competitive salary and benefits. Please respond with C.V. to Carla Kachmar, Vice President — Medical Staff Services, Akron General Medical Center, 400 Wabash Avenue, Akron, OH 44307.

NORTHERN OHIO: Full-time Directorship position available for qualified Board Certified/Board Eligible Physician in immediate proximity to exciting, cultural metropolis. Excellent advancement opportunities with expanding, well-established Emergency Department Management Firm. ACA Physicians enjoy competitive remuneration, paid malpractice insurance, CME allotment, flexible scheduling, assistance with relocation expenses, paid life insurance and the opportunity to coverage for three Urgent Medical Care facilities in Columbus. Six new facilities being built. Contact Primary Medical Associates, Inc., 340 East Town Street, Columbus, Ohio 43215, (614) 228-2253, 7:00 a.m.-3:30 p.m.

NORTHEASTERN OHIO. At least two qualified family practitioners needed near Cleveland and Akron. Rapidly growing area. Responsibilities of solo or partnership practice. Send curriculum vitae to Box 120, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, OH 43215.

NORTHEASTERN OHIO Ob-Gyn needed. Attractive, growing area approved 130 bed hospital. Respond to Box 119, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, OH 43215 with curriculum vitae.

OBERLIN, OH — 21 person multispecialty group seeks additional family physicians. Small college town near Cleveland. Salary and benefits leading to equal share in corporation after 1 year. Send CV to Dr. VanDyke, 224 W. Lorain, Oberlin, OH 44074; 216-775-1651.

Family Practice Opportunity

We are assisting a very busy two physician team which seeks a board certified or board eligible family physician to join their growing practice in a middle class neighborhood. This independent practice meshes well with the internists, general surgeons and gastroenterologists who comprise the rest of the West Central Medical Group. The group owns a modern facility with a full range of diagnostic equipment, centralized billing and a medical center computer link for patient demographics, census, lab data and medications.

Although they do not practice obstetrics, theirs is a genuine family practice spanning all ages of diagnoses. The group has a huge loyal following from all of Lucas county, southeastern Michigan and surrounding area. We are seeking a family physician who looks to develop strong relationships with the patients and the community. The successful candidate should possess a strong work ethic and will be required to become board certified within one year.

Toledo is a family oriented, energetic city located on the southwestern shores of Lake Erie. It has an excellent public, parochial and technical school system. Toledo has its own university, it is home of the Medical College of Ohio and Lourdes College. Cultural assets includes one of our nation's ten finest art museums, an excellent symphony, zoo and metro park system, concerts and theatre, continuing education and athletic series, abound with four universities within one hours drive. For prompt consideration, please submit CV to: **Lynn Scott, Manager, Employment and Recruitment.**



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OB-GYN NEEDED: Busy three man practice in central Ohio needs a board qualified Ob-Gyn. We do not perform abortions and seek an individual with same philosophy. Please respond to PO Box 117, c/o Ohio State Medical Association, 600 South High Street, Columbus, OH 43215.

OHIO: Emergency Medicine positions ranging from part-time placements to full-time Directorships. Low to high volume hospitals throughout the state. Guaranteed hourly rate plus malpractice insurance. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

OHIO, NORTHEAST/CLEVELAND: Staff position for Board Certified/prepared in emergency medicine or other primary care specialties for ED. 8000-32000 patient visits per year. Exc. compensation & benefit pkg: pd. health, life, disability, and dental ins; pension and PS plan; educ. stipend; and vac. Professional liability coverage paid by corp. Advancement to shareholder level for well-qualified individual. Please send CV to PO Box 2600, Lakewood, Ohio 44107.

ORTHOPEDICS

Our 45 physician multi-specialty group practice is looking for two full-time orthopedic surgeons to develop our orthopedic service through a time of projected rapid growth and expansion. We are increasing our in-house physical therapy department capacity, renovating and expanding our physical plant and now need our own staff orthopedic surgeons to meet patient needs. Our compensation package is very good and the practice opportunity outstanding. C.V.s to Group Health Associates, 2915 Clifton Avenue, Cincinnati, Ohio 45220.

ORTHOPEDIST — Excellent opportunity for orthopedist in Los Angeles suburb to join 80 member multispecialty medical group. Large fee-for-service and prepaid practice, no Medi-Cal. Excellent compensation program based on guarantee plus incentive, profit sharing and pension plan. Group provides health, dental, life and malpractice. Partnership in real estate and medical corporation

available. Send CV to Wm. Shaw, Associate Administrator, Mullikin Medical Center, 17821 S. Pioneer Blvd., Artesia, CA 90701.

OTOLARYNGOLOGIST NEEDED — for modern, progressive J.C.A.H. accredited hospital. Office space, adjacent to hospital, available. College town of 21,000 with drawing area of 40,000 population. Excellent schools, churches, diversified industry. Contact William C. Kelley, Jr., (419) 289-0491.

OTORHINOLARYNGOLOGIST, PSYCHIATRIST, ENDOCRINOLOGIST RADIOLOGIST AND GENERAL/ FAMILY PRACTITIONER

Excellent opportunity for physicians in Los Angeles suburb to join 80 member multispecialty medical group. Large fee-for-service and prepaid practice, no Medi-Cal. Excellent compensation program based on guarantee plus incentive, profit sharing and pension plan. Group provides health, dental, life and malpractice. Partnership in real estate and medical corporation available. Send CV to Wm. Shaw, Associate Administrator, Mullikin Medical Center, 17821 S. Pioneer Blvd., Artesia, CA 90701. (See our display ad in this issue.)

PEDIATRICIAN — *Solo practice available immediately.* Modern, progressive J.C.A.H. accredited hospital. College town of 21,000 with drawing area of 40,000 population. Office space available. Contact William C. Kelley, Jr., (419) 289-0491.

PHYSICIAN

Group Health Associates is searching for that particular physician interested in working fulltime (40 hours per week) in our Clifton Urgent Care Department. We have an excellent compensation package and good support services. This position requires no hospital responsibilities or continuing patient care. Please send your C.V. to Search Committee, Group Health Associates, 2915 Clifton Avenue, Cincinnati, Ohio 45220.

PHYSICIAN MEDICAL DIRECTOR for rapidly growing ambulatory care center located in a new medical complex in Cleveland suburb. Excellent compensation package with paid vacation, paid professional liability insurance and advancement possibilities. Corporation is highly aggressive, staffing many emergency departments and urgent care centers in the Cleveland area. Training in primary care medicine preferred. Please send CV to PO Box 2600, Lakewood, Ohio 44107.

PHYSICIAN WANTED to join busy, established family practitioner in a lovely college town in Central Ohio. Obstetrics optional. This is a satellite operation of a well-established multispecialty group practice just 18 miles distant. Shareholder status in the parent group available after the first year. Very competitive starting salary with superb fringe benefits. Please reply to PO Box 95, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, OH 43215.

PRIMARY CARE PHYSICIANS. Multi-state practice association seeks BE/BC primary care physicians for unique opportunities in Pa., N.J., New England, Md., Fla., and other areas of the US. Most positions offer Monday-Friday 8 am to 5 pm schedules with up to *five* weeks paid time off. Paid malpractice. Contact or send CV to Liberty Healthcare Corporation, 399 Market Street, Suite 400, Philadelphia, PA 19106, (215) 592-7400 or outside Pa. (800) 331-7122.

PSYCHIATRISTS — Immediate openings for Staff Psychiatrists, full time and part time, board eligible/board certified, in a state-operated, JCAH accredited, 380-bed inpatient psychiatric hospital. Multi-discipline approach with psychiatrist as a treatment team leader, expected to exercise strong leadership in quality care of patients. Programs for acute admissions, extended care, geriatrics and psychiatric rehabilitation. License to practice in the state of Ohio is required. We are located about 20 miles from Akron, population: 300,000; excellent school system and outdoor activities. Massillon and adjacent Canton has a combined population of 110,000. Salary starts at $54,308 annually, with expected increase to $57,034 on 1/1/87. Excellent fringe benefits including paid vacation and personal leave, sick and educational leave, health, vision, dental and life insurance, etc. Travel costs may be negotiated. Faculty appointment to the Northeastern Ohio University College of Medicine possible for qualified applicants. EEO Employer, M/F/H.
Send resume to W.J. Roberts, Director of Personnel, Massillon State Hospital, Box 540, Massillon, OH 44648, or call (216) 833-3135, ext. 223.

RADIOLOGY

Group Health Associates is a 45 member multi-specialty group practice searching for a full-time board eligible/board certified radiologist to complement our existing radiology staff. We operate an entirely ambulatory service to include IVP, fluoroscopy, ultrasound, mammography, etc. We project continued aggressive expansion and growth of the group as a whole and of the radiology department in particular. Please send C.V.s to Search Committee, Group Health Associates, Inc., 2915 Clifton Avenue, Cincinnati, Ohio 45220.

SEEKING INTERNAL MEDICINE ASSOCIATE TO JOIN INTERNIST, ESTABLISHED CLIENTELE — city NW Ohio 40,000. Modern equipped office; x-ray, lab with technician. Attractive offer at 50% of shares offered now and in 4 years or less vested to full ownership. **INTERVIEW REQUESTED.** Please call Dr. Thomas Shoupe at 419-422-7622 for more information.

THE OHIO STATE UNIVERSITY Department of Internal Medicine has two openings in its new Division of Community Internal Medicine. This South Central Ohio primary care general medicine group will consist of six general internists in a key referral area to the University. Full-time faculty appointments will be offered, with the full range of fringe benefits. Salary negotiable. Positions available January 1987. Please send resume to Ernest L. Mazzaferri, MD, Chairman, Department of Internal Medicine, 215 Means Hall, 1654 Upham Drive, Columbus, Ohio 43210-1228. The Ohio State University is an Affirmative Action/Equal Opportunity Employer.

continued on next page

Equipment

FOR SALE: 4 Channel console with telemetry and all accessories for monitoring cardiac rehab patients. Like new condition. Please send reply to: Box 108, c/o Ohio State Medical Journal, 600 S. High St., Columbus, OH 43215.

MEDICAL EQUIPMENT — FOR SALE: M Mode Echocardiogram IREX Machine in excellent working condition. We are updating our equipment. Please call 1-800-592-6188 and ask for Venita.

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MEDICAL PRACTICE SALES AND APPRAISALS: We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our brokerage division at: The Health Care Group, 400 GSB Building, Bala Cynwyd, PA 19004 (215) 667-8630.

Position Wanted

BOARD CERTIFIED CARDIOLOGIST (internist) Invasive-Non Invasive, Ohio and Kentucky licensed, wishes to join group or hospital in Cincinnati, Cleveland, Toledo. Reply to Box No. 97, c/o Ohio State Medical Journal, 600 S. High St., Columbus, OH 43215.

BOARD CERTIFIED INTERNIST-CARDIOLOGIST, Ohio and Kentucky licenses, seeks emergency room Cincinnati, Northern Kentucky. Reply to Box No. 98, c/o Ohio State Medical Association, 600 S. High St., Columbus, OH 43215.

Practice for Sale

CINCINNATI, OHIO physician to take over a well-established solo practice in a beautiful small community that is only 30 minutes from downtown Cincinnati. Sale price is favorable and the doctor will stay to introduce to the patients. The office has a excellent location in a beautiful restored old home. There is a minimal amount of obstetrics and pediatrics and may be attractive to an internist. Doctor retiring soon. Contact G.T. Bowen, MD, (812) 537-4888.

PRACTICE FOR SALE: General surgery with general practice for sale — active and well established in Eastern suburb of Cleveland, Ohio — oper. staff hospitals nearby. Reply with CV to Box 114, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, OH 43215.

Seminars

1987 CME CRUISE/CONFERENCES ON SELECTED MEDICAL TOPICS — Caribbean, Mexico, Hawaii, Alaska, China/Orient, Scandinavia/Russia. 7-14 days year round. Approved for 20-24 CME Cat. 1 credits (AMA/PRA) and AAFP prescribed credits. Distinguished professors. FLY ROUNDTRIP FREE ON CARIBBEAN, MEXICAN & ALASKAN CRUISES. Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, NY 11746. (516) 549-0869.

OCCUPATIONAL MEDICINE TRAINING
Mini-Residency beginning June 8-19, 1987 and continuing October 12-16, 1987 and March 14-18, 1988. Clinical & Administrative Occupational Medicine, Epidemiology & Biostatistics, Industrial Hygiene, Toxicology, Regulations, etc. 111 AMA Cat I, AAFP prescribed, Cat 2-D AOA and Cat I ACEP credits. 11th year. References from past participants provided. $650 per week. Sidney Lerner, MD, College of Medicine, Mail Location 182, Cincinnati, Ohio 45267-0182, 513-872-4043.

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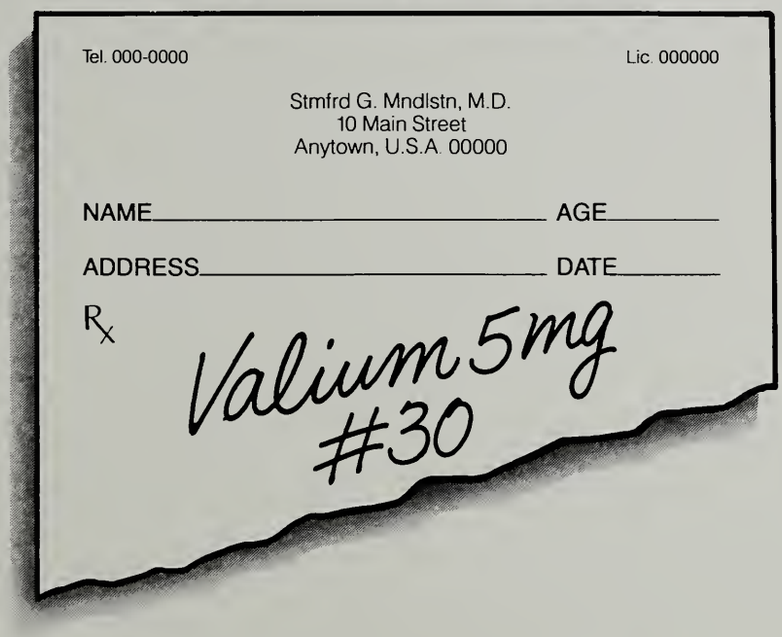
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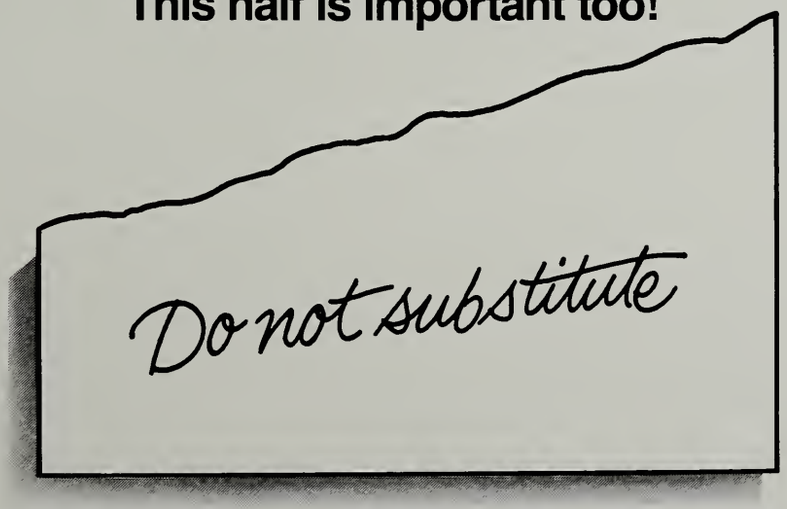
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